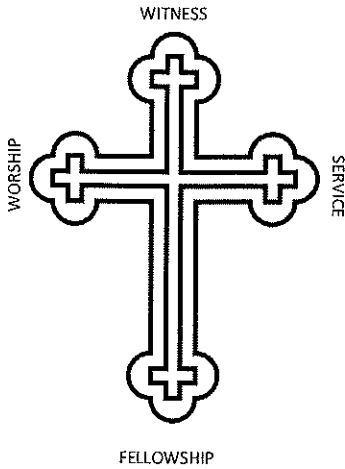


FAITH, HOPE & JOY OF ST. BARBARA

REGISTRATION 2015-2016

**Suggested donation per child \$10.00
Remind- Text 81010 and type @faithhop in the message line*



Child's Name: _____ Date of Birth: _____ Age: _____

Mother's Name: _____ Cell Phone # _____ Text Y / N

Father's Name: _____ Cell Phone # _____ Text Y / N

Address: _____

Home Phone: _____ Email: _____ @ _____

Please circle: **Dropping off my child** **Staying to volunteer at FAITH/HOPE/JOY**

Does your child have any medical problems of which we should be aware? _____

Any Allergies? _____

Type of Reaction (be specific) _____

Does your child have a prescription for an epi-pen? Yes No (circle one)

Please provide the name and telephone number of two persons that we may contact if your child is ill or injured. In the event that the parent or guardian cannot be contacted, these persons have your permission to make a decision:

1. Name _____ Telephone _____

2. Name _____ Telephone _____

FAMILY DOCTOR'S NAME _____ Telephone _____

HOSPITAL OF CHOICE _____

EMERGENCY MEDICAL TREATMENT

To the Advisors and Priest:

In the event that I am unable to be reached and my child needs EMERGENCY MEDICAL TREATMENT during any time he/she is a member of the FAITH/HOPE/JOY, you have my permission and I hereby designate you my agency, to act as my agent for my son's/ daughter's best interest in obtaining necessary transportation and medical care until I can be contacted. I hereby release the Advisors, Priest and Church of any claim arising out of the doctor's actions, and I assume and agree to pay for any medical services incurred.

Parent/Guardian Signature _____ Date _____

Permission for emergency medical treatment will be effective throughout the enrollment. If there is any change of information, please contact the Priest or Advisors.

**\$10.00 Donation will help defray the cost of pizza and drinks for the children*