



## St. Matthew Catholic Church Vacation Bible School 2018

June 25<sup>th</sup> through June 29<sup>th</sup>  
 9:00 a.m. - Noon  
 Rising Kindergarten - Rising Sixth Grade  
 \$35 per child \*

FAMILY NAME: \_\_\_\_\_ Home Telephone: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
Number & Street City Zip Code

Daytime Telephone: \_\_\_\_\_ / \_\_\_\_\_  
Father Mother

Emergency Contact: \_\_\_\_\_  
Name Phone Relationship to child

Child(ren) may be picked up by:  Parents  Brother/Sister  Other: \_\_\_\_\_  
(Specify name & relationship)

| Student's Name |       |     | M | F | Date of Birth | T-Shirt Size | Grade<br>Entering<br>Fall 2018 |
|----------------|-------|-----|---|---|---------------|--------------|--------------------------------|
| Last           | First | M.I |   |   |               |              |                                |
|                |       |     |   |   |               |              |                                |
|                |       |     |   |   |               |              |                                |
|                |       |     |   |   |               |              |                                |
|                |       |     |   |   |               |              |                                |
|                |       |     |   |   |               |              |                                |

**PLEASE COMPLETE THE PERMISSION SLIP ON THE  
REVERSE SIDE OF THIS FORM.**

Registration forms and payment may be dropped off or mailed to the Religious Education Office.

Please make checks payable to *St. Matthew*  
 8200 Robert E Lee Drive  
 Spotsylvania, VA 22551  
 540-582-5575

**\* No fee is charged for children of volunteers**

Saint Matthew Catholic Church  
8200 Robert E Lee Drive  
Spotsylvania, VA 22551

**PERMISSION SLIP AND MEDICAL RELEASE**

I, \_\_\_\_\_(parent/guardian) give permission for my child(ren) listed on the front of this form, to participate in the St. Matthew Vacation Bible School from Monday June 25<sup>th</sup> through Friday June 29<sup>th</sup> from 9:00 a.m.- Noon.

In the event that I cannot be reached, I hereby grant permission for my child to be evaluated, diagnosed, treated and/or medicated in accordance with standard medical practice by licensed medical personnel.

Please provide all necessary information about insurance:

Insurance Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

I will not hold Saint Matthew or the Diocese of Arlington, chaperones, or representatives in association with this activity responsible in the event of injury.

My Child is Allergic to (Medication-food-other) \_\_\_\_\_

My child is taking medication (indicate dosage, frequency, etc.):

\_\_\_\_\_

You should be aware of these special medical conditions of my child (dietary, asthma and other concerns):

\_\_\_\_\_

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I understand that photos of the children will be taken during activities and hereby grant permission for my child(ren)'s image to be displayed in a photo or media slide show presentation that will not be distributed to anyone.

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_