St Olaf Summer Camp

2023 Vacation Bible School Registration
St. Olaf Catholic Church
July 31-August 3, 9am-12noon

FAMILY INFORMATION

Last Name (name under which this form is to be filed) _____

Parent/Guardian _____ Phone _____

Please circle one: Primary Secondary

Parent/Guardian _____ Phone _____

Please circle one: Primary Secondary

Family E-mail _____

VACATION BIBLE SCHOOL PARTICIPANTS

Please list the first name (and last if different than above), age and grade entering for each child you are registering.

Name _____ Age _____ Grade _____

Name _____ Age _____ Grade _____

Name _____ Age _____ Grade _____

Name _____ Age _____ Grade _____

ALLERGY INFORMATION

Please list any food or other allergies for your child(ren) along with their name.

_____

_____

FEES

If the cost could prohibit you from participating, please speak to the Director of Faith Formation about installment plans as soon as possible.

$25.00 per child before July 21st

Checks should be made payable to *St Olaf Parish*.

Registration deadline: Friday, July 21.

Please call or e-mail the Faith Formation Office with any questions:

Robin Johengen
Director of Faith Formation
715-832-2504, x103
rjohengen@saintolafparish.org

(Please fill out the reverse of this form and drop off with payment in the parish office or mail to: PO Box 1203, Eau Claire, WI 54702-1203)

DIOCESE OF LA CROSSE - ST. OLAF FAITH FORMATION
COMPREHENSIVE CHILD CONSENT AND RELEASE FORM
Parental/Guardian Consent Form and Liability Waiver

Participant's full name	Birth date	Sex

Parent/Guardian's name: _____

Home phone: _____ Cell phone: _____

PERMISSION TO USE PARTICIPANT PHOTOS: You have my permission to use said participant's photos (for parish newsletters, bulletins, social media, etc.).

Initials of Parent/Guardian: _____ Date: _____

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child.

***EMERGENCY MEDICAL TREATMENT*:** In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Parent/Guardian Name & relationship: _____

Family doctor: _____ Phone: _____

Family Health Plan Carrier: _____ Policy #: _____

Signature: _____ Date: _____

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