CCN Children's Ministry Registration

Please complete this form for *each child* participating in children's ministry.

Child's Name: (Last) _____ (First) _____

Birth Date: _____ Male: _____ Female: _____

Home Address: _____

City/State/Zip: _____

Day Phone: (___)_____Eve Phone: (___)_____

Custodial Parent(s) / Guardian(s): _____

Home Phone: (____)_____ Mobile Phone: (___)_____

Home Address: (If Different): _____

Health Plan Carrier: _____

Name Of Insured: _____

Relationship To Policyholder: _____

Policyholder/Insurance Id: _____

Family Doctor: _____ Office Phone: (_____)_____

Emergency Contact: _____

Relationship To Participant: _____

Home Phone: (____)_____ Day Phone: (____)_____

List any court-appointed restrictions: _____

Those authorized to pick up my child are:
(Must list first/last name & relationship to you)

_____

_____

_____

Medical Information

Please complete this form so health providers can be aware of your child's health needs.

Child's Name: _____

Does child have: (If "yes", explain)

Yes _____ No _____ Allergies? _____

Yes _____ No _____ Heart Condition? _____

Yes _____ No _____ Diabetes? _____

Yes _____ No _____ Other? _____

Is child subject to: (If "yes", explain)

Yes _____ No _____ Headaches? _____

Yes _____ No _____ Seizures? _____

Yes _____ No _____ Motion Sickness? _____

Yes _____ No _____ Fainting? _____

Yes _____ No _____ Upset Stomach? _____

Yes _____ No _____ Other? _____

Does child have reaction to: (If "yes", explain)

Yes _____ No _____ Bee Sting? _____

Yes _____ No _____ Penicillin? _____

Yes _____ No _____ Other Drugs? _____

Yes _____ No _____ Poison Ivy, Oak, Sumac? _____

Yes _____ No _____ Peanuts? _____

Yes _____ No _____ Other? _____

Does child have any condition that would prevent him/her from participating in any of the activities of this program?

Yes _____ No _____

Does child take any prescription medications?

Yes _____ No _____

Does child have any sight or hearing impairment?

Yes _____ No _____

Does the child wear contact lenses?

Yes _____ No _____

Does the child wear hearing aids?

Yes _____ No _____

Blood type: _____ Date of last tetanus shot: _____

Please indicate anything else that the caregivers should know about your child:

_____

_____

_____

(Nursery-age children) Is there anything that is especially comforting to your child, ex. a favorite blanket, a song, a pacifier, a story, a particular way of being held, etc.

_____

_____

_____

Authorization

Parent/Guardian _____ Date _____
(Signature)

Parent/Guardian _____ Date _____
(Signature)

Witness: _____ Date _____