Appendix H

TRINITY UNITED CHURCH OF CHRIST
YOUTH REGISTRATION FORM

Program Year: September 1, _____ - August 31, _____

1. **Name of Youth:** _____ DOB: _____ Age: ____

   Grade: _____ School: _____

2. **Name of Youth:** _____ DOB: _____ Age: ____

   Grade: _____ School: _____

3. **Name of Youth:** _____ DOB: _____ Age: ____

   Grade: _____ School: _____

Parent/Guardian: _____

Address: _____ _____ _____
(Street) (Town) (State) (ZIP)

Phone: (Home) _____ (Cell) _____

E-mail: _____

Emergency Contact: _____
(in the event parent/guardian cannot be reached)

Relationship to Youth: _____

Address: _____ _____ _____ _____
(Street) (Town) (State) (ZIP)

Phone: (Home) _____ (Cell) _____

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General Field Trip Permission: I hereby give permission for the youth listed above to accompany his/her church group on field trips as planned by Trinity United Church of Christ throughout September 1, _____ - August 31, _____. I understand I will be notified of specific individual events/activities and will complete, sign and return specific permission forms. I hereby grant permission for my child to be photographed while participating in youth activities and for these photographs to be used for display, publicity and youth projects.

Medical Release: I, the undersigned parent/guardian of the youth listed on this form do hereby give permission for any Trinity United Church of Christ approved adults to treat said youth for minor injuries and to take him/her to a hospital for medical treatment when I cannot be reached or when delay would be dangerous to the health of the child. I consent to any examinations, x-ray, anesthesia, medical or surgical

diagnosis/treatment and hospital care that may be rendered to said minor, under the general specific instructions of _____ (name of participant's physician) or, if unavailable, by an on-call physician at a hospital or clinic. It is understood that this consent is given before any specific diagnosis or treatment and is given to encourage those persons who have temporary custody of my child, in my absence, and said physician to exercise their best judgment as to the requirements of such diagnosis or said medical treatment delivered to said persons entrusted with the care, custody and control of said child. This consent will remain effective until August 31, _____. I understand that any medical expenses incurred are my responsibility and that there is no medical insurance coverage provided by Trinity United Church of Christ.

Signature of parent/guardian: _____Date: _____

Medical Data:

Physician: _____ Phone: _____

Insurance Company & #: _____

Health History

1. Youth Name: _____
Check all that apply:
___ Asthma ___ Medications: (please list)
___ Diabetes
___ Epilepsy
___ Heart Disease / Defects ___ Allergies: (please list in red)
___ Other (specify)

2. Youth Name: _____
Check all that apply:
___ Asthma ___ Medications: (please list)
___ Diabetes
___ Epilepsy
___ Heart Disease / Defects ___ Allergies: (please list in red)
___ Other (specify)

3. Youth Name: _____
Check all that apply:
___ Asthma ___ Medications: (please list)
___ Diabetes
___ Epilepsy
___ Heart Disease / Defects ___ Allergies: (please list in red)
___ Other (specify)