



Children's Church Registration Form

MPBC of Gainesville

Personal Contact Details

Family Name/s: _____ Name of Child: _____

Date of Birth: / / Preferred Name: _____

Address: _____

Phone: _____ Mobile: _____ E-mail: _____

Alternate emergency contacts (Optional):

1. Name: _____ Relationship to child: _____ Phone: _____

2. Name: _____ Relationship to child: _____ Phone: _____

Please give details (name and phone number) of other persons who you authorise to collect your child/ren in your absence, while in the care of the above-named group:

1. _____ 2. _____

Privacy Information

*All the information recorded on this form is collected and managed in accordance with the Church Privacy Policy. This information has been collected for the primary purpose of **MPBC of Gainesville** and may be used for any activities conducted or promoted by the **MPBC of Gainesville**. All information is confidential and only shared with the appropriate pastoral staff deemed necessary.*

Permission to Participate in Program Activities

I consent to my child taking part in the approved program of activities for the **MPBC Children's Ministry**.

Signed _____ Date _____

Please Complete Reverse Side

Permission to View Video Tapes and DVDs

I consent to my child viewing VHS tapes or DVDs rated (G) General.
I understand that all material will be previewed by a leader to check suitability.

Signed _____ Date _____

Permission to be Photographed or Filmed

I give my permission for my child to be photographed or videotaped. I understand that the image may be displayed in the church publications, church buildings or website. I understand that as a precaution my child's name will not be published or linked with photographs.

Signed _____ Date _____

Confidential Medical Report

The information below is requested to assist in case of any illness or accident. This information will be held in confidence.

1. Please tick if your child suffers from any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Heart condition; | <input type="checkbox"/> Sleepwalking; |
| <input type="checkbox"/> Blackouts; | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Asthma; | <input type="checkbox"/> Other (please specify |

:

2. Is your child presently taking medication? Yes / No *If yes, please state the name of the medication, dosage, etc.*

_____ Does your child self-administer? Y / N

3. Is your child allergic to:

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> bee stings |
| <input type="checkbox"/> Other drugs or food (please specify) | _____ |

4. Please list any physical or special needs: (eg. Dietary requirements)

I authorise the leader/s in charge of the above mentioned group where it is impractical to communicate with me, to arrange for my child to receive such medical or surgical treatment as the leader/s may deem necessary at any time during the activities of **MPBC of Gainesville**.

I further authorise the use of Ambulance and/or anaesthetic by a qualified medical practitioner if in his/her judgement it is necessary. I accept responsibility for payment of all expenses associated with such treatment.

I appreciate that every care will be taken by the leaders and those connected with that group cannot be held responsible for personal injury, loss or theft of property affecting my child.

Signature of
Parent/Guardian: _____ Name: _____ Date _____