



# KID'S KLUB REGISTRATION FORM

Fall Session: 10/1, 10/29, 11/5, 11/19, 12/10

Spring Session: 1/7, 1/21, 2/11, 2/25, 3/11, 4/8, lead worship 4/15

Program Time: Sundays from 5:00 – 7:00 P.M.

Fall Session: \$25 \_\_\_\_\_; Spring Session \$25 \_\_\_\_\_; Both Sessions:\$40 \_\_\_\_\_

Additional Participants: Fall Session \$20 \_\_\_\_\_; Spring Session: \$20 \_\_\_\_\_; Both Sessions\$35 \_\_\_\_\_

Child's name \_\_\_\_\_ Nickname \_\_\_\_\_

Birth date \_\_\_\_\_ Current age \_\_\_\_\_ Grade \_\_\_\_\_

Allergies or other health concerns: \_\_\_\_\_

Important information we need to know about your child:

\_\_\_\_\_

Parent(s)/Guardians \_\_\_\_\_

Address \_\_\_\_\_

Email(s) \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

\_\_\_\_\_

Emergency contact: Name \_\_\_\_\_ relationship \_\_\_\_\_

Contact Information \_\_\_\_\_

Medical Insurance \_\_\_\_\_

*In case of an emergency and we are unable to contact you or your emergency contact, do we have permission to seek medical help from a licensed doctor or dentist? Yes / No*

**Parent signature** \_\_\_\_\_

Family Doctor \_\_\_\_\_ phone \_\_\_\_\_

Family Dentist \_\_\_\_\_ phone \_\_\_\_\_

**Photo/Video waiver:** I understand that my child may be photographed or recorded during Kids Klub events. By initialing below I give consent for their image to be used in either print, electronic or video form for the promotional purpose of future DPC youth events. I also understand that my child's name will remain anonymous.

Initials of parent or guardian: \_\_\_\_