Vacation Bible School
Registration Form
Hilltop Covenant Church

82 Hicksville Road
Cromwell, CT 06416
860-635-4032

Dates: August 9 through August 13 **Time:** 9:00 AM – 12:00 noon
Age Range: 4 - 12
Cost: $15 per child ($10 per child for each additional child in a family)
Make Check Payable to: Hilltop Covenant Church
Registration Due: preferably by August 2
Mail or bring Registration Form and Fee to the Address Above.
Call with Questions: Sally Huggins, Office Secretary

_____

Child's Name Date of Birth

_____

Name and ages of additional child(ren) in the same family who will be attending.

_____

Address

_____

Parent or Legal Guardian Daytime Phone

I understand that in the event medical treatment is required, every effort will be made to contact me. However, if I cannot be reached, I give permission to Hilltop Covenant Church leaders to secure the services of a licensed physician to provide the care needed. We realize that no activity is without the possibility of unforeseen hazards which could result in injury to an individual. As a parent or guardian, you are aware of your responsibility to instruct your child about the importance of good conduct which will insure safety and an enjoyable time while participating in this activity. By signing this form, I, as a parent, guardian or other responsible party, agree to assume the risks and hazards which are inherent in this kind of activity. I also agree to absolve and hold harmless the sponsoring organization and its representatives for damage, loss or injuries to the child for whom I sign. I further give my permission for the use of any photo or likeness of my child to be used by the sponsoring organization for their use in promotional materials.

_____ _____ _____

Parent's/Guardian's Printed Name *Signature* *Date*

_____ _____

Doctor's Name *Phone Number*

_____

Emergency Contact Person Relationship to child Daytime Phone

The following person(s) have permission to transport my child to and/or from Hilltop Covenant Church:
Name: _____ Phone: _____
Name: _____ Phone: _____

Medical/ Health/ Allergy Information:_____

_____

_____

For office use: $_____ amount paid on (date) _____