



# Christian Life Fellowship

P.O. Box 40, 600 7th Street

Port Edwards, WI 54469

(715) 887-3565 (715) 887-3575 FAX info@clfonline.org

# Registration & Release for minors

### Student Information: (Please complete a copy of this form for each minor youth/child.)

Full Name:	Nick Name:
Address:	Birthday (including year):
City, State ZIP:	Gender:
School Name:	School Grade:
Youth/Child's Email Address:	Youth/Child's Personal Phone:

### Parental Information:

Father's Name:	Father's Day/Work/Cell Phone:
Mother's Name:	Mother's Day/Work/Cell Phone:
Custodial parent(s):	Home Phone:
Parent Email Address:	
Home Church if not CLF:	

### Medical Information:

Physician's Name & Phone:	<b>Group Registration Check all that apply</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Youth Group</li> <li><input type="checkbox"/> Sunday Night CE</li> <li><input type="checkbox"/> Jr. Bible Quiz</li> <li><input type="checkbox"/> DC4K (Divorce Care for Kids)</li> <li><input type="checkbox"/> Rainbows</li> <li><input type="checkbox"/> Daisies</li> <li><input type="checkbox"/> Prims</li> <li><input type="checkbox"/> Stars</li> <li><input type="checkbox"/> Friends</li> <li><input type="checkbox"/> Ranger Kids</li> <li><input type="checkbox"/> Discovery Rangers</li> <li><input type="checkbox"/> Adventure Rangers</li> <li><input type="checkbox"/> Expedition Rangers</li> </ul>	
Health Insurance Co. & Policy:		
Known Allergies:		
Current or Chronic Conditions:		
Medication now taking:		
Are immunizations current?		Last Tetanus vaccination date:
Is there anything that will prevent or restrict student's participation? If Yes, please explain:		

### Emergency Contact: (if parent is not available)

Name:	Relationship to student:
Address:	Phone:

### Medical & Liability Release:

In the event of sickness, injury or medical emergency, I request that my child receive any medical attention or treatment deemed necessary. Therefore, I give permission to any hospital, doctor and/or health care provider to transport, treat and admit for care my child and to release information pertaining to the diagnosis and treatment of my child to CLF staff or volunteer personnel. I understand I am responsible for all expenses and charges for any treatment or care provided. In the event that I am not present at the time of the emergency and can not be contacted, our child has been entrusted to the staff and designated ministry leadership of Christian Life Fellowship while attending any church related function or activity both on and off church grounds. I also authorize Christian Life Fellowship to disclose my child's personal and medical information with staff and volunteers that will be caring for my child as well as with any health care provider. I also release Christian Life Fellowship, its agents, staff, employees and volunteer workers from any liability whatsoever arising out of property damage or loss as well as any injury, sickness or death which may be sustained by my child as the result of any participation in church sponsored or related functions or activities.

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_