

CCO BIBLE SCHOOL 2007-2008 REGISTRATION FORM

CHILD'S NAME: _____ BIRTHDATE: _____ AGE: _____

ADDRESS: _____
_____ (Zip Code)

PHONE NOS: () _____ (Home)
() _____ (Cell Phone)
() _____ (Business)

E-Mail Address

ADDITIONAL PERSON TO CONTACT
IN THE EVENT OF AN EMERGENCY: _____
(Name and Phone No.)

Please Check <input checked="" type="checkbox"/>:	
<input type="checkbox"/> Child Has Permission Walk Home Alone from Bible School <input type="checkbox"/> Child Does Not Have Permission to Walk Home	Parent/Legal Guardian is: <input type="checkbox"/> Tither to CCO <input type="checkbox"/> Non-Tither <input type="checkbox"/> Relation of CCO Tither: _____ (Please List Name of Relation)

INFORMAL GUARDIAN AUTHORIZATION CONSENT FOR TREATMENT

In the event that my child (name) _____ becomes ill or sustains an injury while in the care of THE COMMUNITY OF THE CRUCIFIED ONE INC., 104-108 E. ELEVENTH AVENUE, HOMESTEAD, PA 15120 (PHONE (412) 462-9537)), I the undersigned, grant the authority to THE COMMUNITY OF THE CRUCIFIED ONE, INC. to act on my behalf in obtaining and consenting to any medical treatment that may be necessary, including but not limited to: X-ray examination, anesthetic, medical, dental, or surgical diagnosis and treatment, hospital care, administration of drugs or medicine, under the supervision and upon the advice of a duly licensed physician and/or surgeon. I understand that this consent will apply only to non-elective medical procedures, and that a copy of this form is as valid as the original. However, THE COMMUNITY OF THE CRUCIFIED ONE, INC. will not assume financial responsibility for medical treatment that may be necessary. The parent or legal guardian must be willing to accept financial responsibility for illness or injury at Bible School.

This consent is to be effective from SEPTEMBER 1, 2007 until AUGUST 31, 2008.

Child's medical condition (please write a brief description including present medications and special health problems).

 Allergies (including food or any dietary restrictions): _____ Date of Last Tetanus Shot: _____

Check here for no allergies.

FAMILY DOCTOR: _____ PHONE: () _____
 TYPE OF INSURANCE: _____ 800 #: _____
 MEDICAL I.D.: _____ GROUP #: _____

 PRINTED NAME OF PARENT OR LEGAL GUARDIAN

 SIGNATURE OF PARENT OR LEGAL GUARDIAN

 DATE