

All ages welcome!  
3 years old - 6<sup>th</sup> grade in Fall  
Members & nonmembers

**VBS REGISTRATION 2017**  
**June 12 - 15**  
**9:00 – 12:00 p.m.**



*Each family with children attending VBS must fill out a complete form, front & back.*

Last Name \_\_\_\_\_

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ M / F Grade Fall 2017 \_\_\_\_\_ Shirt size \_\_\_\_\_ Youth or Adult

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ M / F Grade Fall 2017 \_\_\_\_\_ Shirt size \_\_\_\_\_ Youth or Adult

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ M / F Grade Fall 2017 \_\_\_\_\_ Shirt size \_\_\_\_\_ Youth or Adult

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ M / F Grade Fall 2017 \_\_\_\_\_ Shirt size \_\_\_\_\_ Youth or Adult

PARENT'S/CAREGIVER'S NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP CODE \_\_\_\_\_

PREFERRED PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

Name(s) of people **prohibited** from picking up my child/children \_\_\_\_\_

In case of an emergency contact \_\_\_\_\_

Relationship to child/children \_\_\_\_\_ PHONE \_\_\_\_\_

Please check box to indicate you completed the Medical & Behavioral Questionnaire on the back of this form.

**Nonrefundable Registration Fee: \$15 per child, \$40 maximum per family**

Checks payable to: Cross of Hope Lutheran Church

Mail or bring registration form and payment to: Cross of Hope Lutheran Church

5730 179th Lane NW, Ramsey, MN 55303

Phone: 763-753-2057, [www.crossofhope.net](http://www.crossofhope.net)

*By signing, I release Cross of Hope and all employees and volunteers from any claims made by participant. My signature also indicates that I grant Cross of Hope the perpetual, non-exclusive, royalty-free right and license to record my participation and appearance on digital or film photography, video tape, audio tape or any other medium. This grant of rights is made voluntarily by me. I further agree to release and forever discharge Cross of Hope, its agents, employees, and designated representatives, from any and all claims in law or equity that I, my heirs or personal representatives, have or shall have arising out of Recordings.*

Parent or Guardian signature (if under 18): \_\_\_\_\_

Office use only  
\_\_\_\_ Check, # \_\_\_\_\_  
\_\_\_\_ Cash  
\$ \_\_\_\_\_ Total Amount  
\_\_\_\_ Received VBS  
\_\_\_\_ Music CD

\*Scholarships available on a limited basis:

\_\_\_\_ If in need of assistance (*please check mark*)

\_\_\_\_ If interested in contributing to the scholarship fund (*please check mark*)

**PREREGISTRATION IS RECOMMENDED** - it helps us organize crews more easily & order enough VBS CD's, t-shirts, & supplies - Thank you!  
For any questions, please contact the church office: 763-753-2057

# Medical & Behavioral Questionnaire

Please check any applicable information that might be helpful for VBS volunteers to make this a fun & rewarding experience for your child.

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**1<sup>st</sup> Child's Name** \_\_\_\_\_ **Age** \_\_\_\_\_

- No Known Allergies
- Food Allergies (List allergy & type of reaction) \_\_\_\_\_
- Insect Sting Allergy (List type & reaction) \_\_\_\_\_ Bringing EpiPen (Yes or No)
- Asthma/Respiratory Condition (explain) \_\_\_\_\_ Bringing Inhaler (Yes or No)
- Attention Deficit Disorder       Hearing Impaired/Deaf       Seizure History       Diabetes
- Medical Allergies(List & reaction) \_\_\_\_\_

**2<sup>nd</sup> Child's Name** \_\_\_\_\_ **Age** \_\_\_\_\_

- No Known Allergies
- Food Allergies (List allergy & type of reaction) \_\_\_\_\_
- Insect Sting Allergy (List type & reaction) \_\_\_\_\_ Bringing EpiPen (Yes or No)
- Asthma/Respiratory Condition (explain) \_\_\_\_\_ Bringing Inhaler (Yes or No)
- Attention Deficit Disorder       Hearing Impaired/Deaf       Seizure History       Diabetes
- Medical Allergies(List & reaction) \_\_\_\_\_

**3rd Child's Name** \_\_\_\_\_ **Age** \_\_\_\_\_

- No Known Allergies
- Food Allergies (List allergy & type of reaction) \_\_\_\_\_
- Insect Sting Allergy (List type & reaction) \_\_\_\_\_ Bringing EpiPen (Yes or No)
- Asthma/Respiratory Condition (explain) \_\_\_\_\_ Bringing Inhaler (Yes or No)
- Attention Deficit Disorder       Hearing Impaired/Deaf       Seizure History       Diabetes
- Medical Allergies(List & reaction) \_\_\_\_\_

**4th Child's Name** \_\_\_\_\_ **Age** \_\_\_\_\_

- No Known Allergies
- Food Allergies (List allergy & type of reaction) \_\_\_\_\_
- Insect Sting Allergy (List type & reaction) \_\_\_\_\_ Bringing EpiPen (Yes or No)
- Asthma/Respiratory Condition (explain) \_\_\_\_\_ Bringing Inhaler (Yes or No)
- Attention Deficit Disorder       Hearing Impaired/Deaf       Seizure History       Diabetes
- Medical Allergies(List & reaction) \_\_\_\_\_

## Behavioral Information:

- No behavioral concerns for my child/children
  - Separation anxiety from parents/caregivers (Child's name) \_\_\_\_\_
  - Challenges with change of routine (Child's name) \_\_\_\_\_
  - Tends to wander or leave classroom without permission (Child's name): \_\_\_\_\_
  - Short attention span or easily distracted (Child's name) \_\_\_\_\_
  - Biting or hitting when angry or frustrated (Child's name) \_\_\_\_\_ What does your child respond best to when calming her/him down? \_\_\_\_\_
  - Other helpful suggestions for those caring for your child/children \_\_\_\_\_
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Thank you! We hope your child has a wonderful time at VBS!

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