Parent Info

Mom's Name ______________________ Dad's name ______________________

Mom's Email ______________________ Dad's Email ______________________

Mom's Phone ______________________ Dad's Phone ______________________

Child(ren) live with: Both parents( ) Mom( ) Dad( ) Mom/Step-Dad( ) Dad/Step-Mom( ) Grandparent( ) Other ______________

I/We will be attending the Parent Class Y N Childcare needed Y N (Cost is $5 per child each week)

Child's Physical Address #1

Street City Zip

Child's Physical Address #2

Street City Zip

Children's Info

Name______________________Birthdate______________Age/Grade______/_________

Name______________________Birthdate______________Age/Grade______/_________

Name______________________Birthdate______________Age/Grade______/_________

Name______________________Birthdate______________Age/Grade______/_________

Please list all allergies/medications/special needs/behavioral diagnoses______________________

Please tell us why you want your child(ren) to participate in Confident Kids Camp:______________________

Fees: $5 - 1st child $3 - 2nd child No charge for additional children from same family

1st Session _____Paid 2nd Session _____Paid 3rd Session ______Paid

Please be advised that the Confident Kids program is a support group only. It is not therapy, nor a substitute for therapy in any way. Our leaders are volunteers, not trained counselors. (If at any time you feel your child is in need of professional counseling services, we will be happy to talk with you about a referral.) All information given by both parents and children will be held in strict confidence. Information shared by children in confidence will not be passed on to adults outside the leadership of the Confident Kids program, except as deemed necessary by the Confident Kids program administrators to ensure the health and safety of the child.
Having read the above and understanding it fully, I herby authorize my child(ren) to be enrolled in the Confident Kids program.

______________________ ___________

Signature of Parent/Guardian Date

Authorization and Release

For any organized church activity we require release, which will allow us to obtain medical care for your child in the event that you cannot be reached. No child will be allowed to attend activities without a signed release on record. This approval will remain effective until revoked in writing or for the period of one year.

Medical Release: In the event of an emergency I understand that a reasonable effort will be made to contact me. If I cannot be reached, I hereby authorize an agent of Parkview Community Church to act on my behalf to seek emergency medical treatment for my child. In the event that such treatment is deemed necessary by that agent. I authorize the physician selected by said agent to administer such emergency treatment as said physician in his/her judgment deems necessary under the circumstances. I understand and agree that I will be responsible for payment of said physician's fee and any and all fees or expenses associated with such treatment. I hereby release Parkview Community Church, its agents and employees from any and all claims and liability resulting from adherence with these instructions.

______________________ ___________

Signature of Parent/Guardian Date

Photo Release

I hereby give my permission for photos and video of my child to be used as deemed appropriate by Parkview Community Church.

______________________ ___________

Signature of Parent/Guardian Date