

**Abiding Presence Youth Group**  
**Registration Form**  
*2009 - 2010*

Name: \_\_\_\_\_ Youth Email: \_\_\_\_\_

Youth Cell Phone: \_\_\_\_\_

***Family Information***

Parent/Guardian Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_

Parents Cell Phone: \_\_\_\_\_

***Emergency Contact Information***

Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

***Medical Information***

Medication or Allergies? \_\_\_\_\_

Is there any other medical or emotional information we should know about your daughter/son?

***Publicity Information***

I give permission for my child to be photographed, video taped, and audio taped at Abiding Presence Lutheran Church or at events sponsored and/or approved by Abiding Presence. I understand that these photos or video/audio tapes may be used for instructional purposes, such as staff training, worship services, and/or general use throughout the church. These photos may also be displayed on bulletin boards at Abiding Presence, on the Abiding Presence web page, or in flyers or brochures promoting the church or our youth and children's programs.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

*Please fill out both sides.*

# PARENT/GUARDIAN CONSENT FORM

I, \_\_\_\_\_, am the parent or legal guardian of  
\_\_\_\_\_.

As the parent or legal guardian of my child, I hereby consent for my child to attend and participate in all activities provided by this church.

\_\_\_\_\_  
SIGNATURE OF PARENT OR GUARDIAN

\_\_\_\_\_  
DATE

Additional Information: My child is to be **excluded** from the following activities:

\_\_\_\_\_  
\_\_\_\_\_

## PARENT/GUARDIAN CONSENT TO MEDICAL, DENTAL, OR HOSPITAL CARE

I, \_\_\_\_\_, am the parent or legal guardian of  
\_\_\_\_\_ who was born on \_\_\_\_\_.

I consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician and surgeon licensed under the Medical Practice Act for my child. This authority also extends to any x-ray examination, anesthetic, dental, or surgical diagnosis or treatment and hospital care by a dentist licensed under the Dental Practice Act for my child. I further agree to pay all charges for the dental, medical, or hospital care or treatment.

As parent or legal guardian of my child, I am responsible for the health care decisions of my child and am authorized to consent to the services to be rendered. I represent that my consent to and agreement to pay for the dental, medical, or hospital care or treatment to be rendered to my child is legally sufficient and that no consent from any other person is required by law.

Dated: \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF PARENT OR GUARDIAN

\_\_\_\_\_  
PRINT NAME OF PARENT OR GUARDIAN