Sunday School

Preschool- 5th Grade // 2018-2019

Student's Name: ____

Birthdate: _______________ **Age:** __________ **Grade:** _______ **M/F**______

School: ____

Parent's Full Name(s) ____

Address: ____

Street City Zip

Phone #: ____________________ ___________________________

Main 2nd

Email: ____

Many opportunities to help----

Teachers and Substitutes needed!

Please mark your contributions below:

Weekly: **Occasional:**

Teacher _____ Substitute _______

(preferred grade or grades) ________________

Does your child need any sort of accommodation to help them learn best or feel more comfortable at Sunday School? How can we help them?

____

____

____

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OVER »

Sunday School Release and Consent Form

Lutheran Church of the Resurrection
Marion, Iowa

Emergency Contact Info

Youth Name:____
Date of Birth: ____________________
Home Address: ____
Parent/Guardian Name: ____
Parent Phone: ____

Emergency Contact Name: ____
(Individual needs to be someone other than the child's parents/guardians who can be contacted if the parents/guardians cannot be reached in the event of an emergency.)

Emergency Contact's Phone: ____
Emergency Contact's Relationship to the child: ____

Authorization to Consent to Medical Treatment

I, We, the parents or legal guardians of ______________________________________, a minor, hereby authorize Lutheran Church of the Resurrection personnel to seek medical attention that may be necessary in emergency situations should they be unable to contact parents/guardians. I, We, hereby, consent to any medical treatment or care deemed necessary by medical personnel or hospital staff. The expense of such treatment is agreed to be the sole obligation of the undersigned, and Lutheran Church of the Resurrection is hereby released from responsibility to pay for such services rendered. We further agree that the Church, Church Council, Church staff and Church volunteers are relieved of all liability in the event of accident or injury.

Medical Insurance Carrier: ____________________________
Hospital Preference: _________________
Family Physician: ___________________________________

Please list any medical conditions or concerns that would affect emergency treatment for your child:

____

List any allergies that would be a health concern or effect emergency medical treatment: (Examples: food, medications, latex, insect stings, etc.)
____
____

(If so does your child carry an EPI Pen? _______________)

Image Consent

I/We do __________ do not __________ give my consent for photographs and video images of my child to be used on the LCR website/social media, classroom videos/posters, church services and/or church publications.

Signature of Parent/Guardian: ____

Date: ______________