



June 22 to 26, 2009
9:00 - 11:45 AM
K - 5th

- ★ MUSIC
- ★ VIRTUES
- ★ GAMES
- ★ CRAFTS
- ★ FUN!

Registration Deadline:
Sunday, June 14, 2009
whipplecreek.com

Whipple Creek Church
8802 NW 9th Ave., Vancouver, Wa. 98665
360-576-0210

Must be completed and returned to Whipple Creek Church. Please print.

Parent Name(s): _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Cell Phone: _____

Email: _____ Home Church: _____

How did you hear about us: _____

My child/children has/have permission to take part in all VBS activities under supervision, and I agree that the VBS or its personnel will not be held responsible for any accidents. I am responsible for any medical obligations incurred during the VBS period and give the VBS staff permission to seek medical treatment for my child in case of injury or illness. I also give permission for the use of photographs including my child in VBS publicity.

Parent/Guardian Signature: _____ Date: _____

IF YOUR CHILD WILL WALK OR BIKE TO VBS ALONE, PLEASE COMPLETE THIS SECTION:

My child/children is/are permitted to walk ___ or bike ___ to VBS each day and will check into VBS without me.

Parent/Guardian Signature: _____

★ Please purchase a white cotton T-shirt for your child. Tear off this slip with the following information filled out and attach it to their shirt.

Child's name _____ Grade _____



★ Bring it with you on June 22nd. ★

APPROVED DRIVER

Name of Person(s) picking up the child: _____

Phone Number of Approved Driver: _____

Relationship to Parent and Child: _____

List days to be picked up: _____

My child has permission to walk home; ride a bike from VBS: Yes _____ No _____

Parent/Guardian Signature: _____ Date: _____

Child #1

Child's Name: _____ Birthdate: / / Age: _____ Grade Next Fall: _____ M _____ F _____

EMERGENCY INFORMATION (In case of emergency notify)

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Relationship to Child _____ Any restrictions to physical activities _____

Health History: (check any that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Frequent sore throats | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Frequent ear infections |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Headaches | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Back pain/strain | <input type="checkbox"/> Heart disease | |

Other Medical Conditions _____

Is the child presently using any type of medication? _____ Specify: _____

Date of last tetanus shot: _____ Date of last physical exam: _____

Allergies

My child has allergies to (please circle): food medication environmental (animal, plant, insect, etc.) other

Describe/specify allergen _____

Type of reaction (please circle): mild moderate (swelling/rash) severe (difficulty breathing)

Details if needed _____

Family Medical Insurance? Yes _____ No _____ Carrier: Policy/Group#: _____

Child #2

Child's Name: _____ Birthdate: / / Age: _____ Grade Next Fall: _____ M _____ F _____

EMERGENCY INFORMATION (In case of emergency notify)

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Relationship to Child _____ Any restrictions to physical activities _____

Health History: (check any that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Frequent sore throats | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Frequent ear infections |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Headaches | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Back pain/strain | <input type="checkbox"/> Heart disease | |

Other Medical Conditions _____

Is the child presently using any type of medication? _____ Specify: _____

Date of last tetanus shot: _____ Date of last physical exam: _____

Allergies

My child has allergies to (please circle): food medication environmental (animal, plant, insect, etc.) other

Describe/specify allergen _____

Type of reaction (please circle): mild moderate (swelling/rash) severe (difficulty breathing)

Details if needed _____

Family Medical Insurance? Yes _____ No _____ Carrier: Policy/Group#: _____