
St Thomas . Penny Street . Lancaster
Worshipping God together and at home, we serve and proclaim Jesus wherever we are.

Parental / Carer Registration & Consent Form for Children & Youth Group Meetings (including for off-site visits) during normal meeting times & not requiring transport

[Note: There is a special shorter form for Sunday morning Junior Church ref: Appendix I]

This form to be completed in full by the parent / carer and returned to the relevant person.

Group name(s) which your child attends.		Please name all the groups for which you are registering your child, there may be several if you include mid-week group meetings.
SECTION A - YOUR CHILD'S DETAILS		
Your child's name		
Their home address		
Post Code		Home tel no.
Child's date of birth		School year
SECTION B - YOUR DETAILS		
Your name(s) as parents/guardians		
Your relationship to the child		
Your usual contact phone no.		
Mobile contact number (optional)		

1. DETAILS OF GROUP

The activities planned for the period fromSeptember 2009... toJuly 2010..... (not more than 12 calendar months) may necessitate the group being taken outside the regular meeting place, but within walking distance and during normal meeting times.

I agree to my son/daughter/ward named above, who is aged 17 or younger taking part in such activities. I acknowledge the need for good conduct and responsible behaviour on his/her part.

2. EMERGENCY DETAILS

a) I agree to my child being given any medical, surgical or dental treatment, including general anaesthetic and blood transfusion, as considered necessary by the medical authorities present.

b) I may be contacted by telephoning the following number(s):

Home: Work Mobile

My address Post Code

c) Please state an alternative contact point

Name of Contact

Address of contact

Telephone no(s)

d) Family Doctor (name)

Doctor's surgery address

Doctor's phone no.

3. MEDICAL INFORMATION

Does your child suffer from any of the following conditions? *Cross out the YES or NO which does not apply.*

Asthma	yes/no	Bronchitis	yes/no
Chest Problems	yes/no	Diabetes	yes/no
Epilepsy	yes/no	Fainting	yes/no
Heart Trouble	yes/no	Migraine	yes/no
Raised Blood Pressure	yes/no	Tuberculosis	yes/no

If YES to any of the above, please provide details:
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Does your child suffer from any other condition requiring medical treatment, including medication? yes/no

If YES, please provide details:
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Is your child allergic or sensitive to any medication (e.g. Penicillin), insect bites or food? yes/no

If YES, please provide details:
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