



St. Paul's
Episcopal Church
Benicia, California

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Student Registration Parental Permission and Medical Consent Form

DATE: _____ FAMILY NAME: _____

HOME ADDRESS: _____ PHONE: _____

1. CHILD'S NAME: _____ DOB: _____ GRADE: _____
BAPTIZED: Y N TAKES COMMUNION: Y N CONFIRMED: Y N ACOLYTE: Y N

2. CHILD'S NAME: _____ DOB: _____ GRADE: _____
BAPTIZED: Y N TAKES COMMUNION: Y N CONFIRMED: Y N ACOLYTE: Y N

3. CHILD'S NAME: _____ DOB: _____ GRADE: _____
BAPTIZED: Y N TAKES COMMUNION: Y N CONFIRMED: Y N ACOLYTE: Y N

OTHER SIBLINGS/AGES: _____

1. PARENT/GUARDIAN: _____ CELL: _____

PREFERRED E-MAIL: _____ WORK #: _____

2. PARENT/GUARDIAN: _____ CELL: _____

PREFERRED E-MAIL: _____ WORK #: _____

3. EMER. CONTACT: _____ PHONE: _____

PROGRAM: Friday Activities for Kids

DATES: 1st, 3rd & 5th Fridays while school is in session

TIME: 2:00 - 4:00

DONATION: \$10/mo. per child; \$20/mo. per family. Scholarships available.

I give permission for my child/children to attend this program on the grounds of St. Paul's and in the local area within walking distance such as the library, park or fire station. St. Paul's may take photographs which include my child/children and use and display the resulting images.

I understand that if my child is demonstrating abusive or inappropriate behavior, St. Paul's will contact me or another person listed above and may request that my child be picked up.

In the case of an emergency, I understand that St. Paul's will make attempts to contact me and/or another person listed above. If no one can be reached in a timely manner, I hereby give my consent to emergency first aid, medical examination, x-ray, anesthetic, medical, dental or surgical diagnosis, treatment and care rendered by or under the general or special supervision of licensed medical personnel.

HEALTH INS. CO: _____ POLICY #: _____

FAMILY DOCTOR: _____ PHONE: _____

MEDICAL CONDITION (Identify child): _____

UNCONTROLLED FOOD ALLERGIES (Identify child): _____

SIGNATURE OF PARENT
OR LEGAL GUARDIAN

