

Jesus RESCUES!

When you are lonely, when you worry, when you struggle!

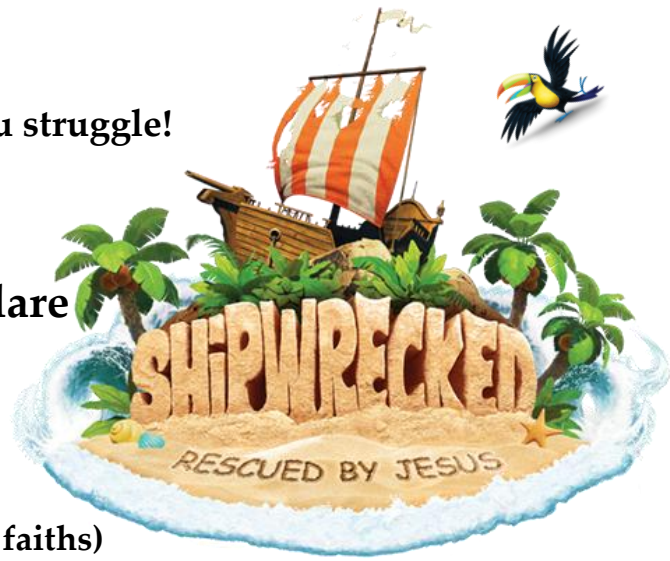
Join our Vacation Bible School



Church of Saint Clare

June 11th – 15th

9:30am – Noon



Open to ALL children

(including non-parishioners & all faiths)

Ages 4 (4 by 9/30/18) up to those just finishing 6th Grade

The fee is \$50 per child which includes daily totally Catholic . . .

*Bible Discovery *T-Shirt *Imagination Station Crafts *Tropical Treats *Castaway Songs *Ship Rec Games

*Evening Program and Open House Thursday June 14th at 7:00pm

Mark your calendars & bring your family and friends for the presentation!

*The children's Annual Vacation Bible School picnic on the last day, June 15th

Please complete this form & check and return it to St. Clare School or church; Attention: Ms. Lori Mascia

Or mail this form with check to: St. Clare Church

5659 Mayfield Rd.

Lyndhurst, OH 44124

Attn: Ms. Lori Mascia



NAMES & AGES OF CHILDREN ATTENDING VACATION BIBLE SCHOOL:

If registering before May 1st, please specify your child's shirt size (Child: Sm, Med, Lg or Adult: Sm, Med, Lg) otherwise, we will order what size we think is best ☺

Name: _____ Last grade completed: ___ Age: ___ Date of Birth: _____ Shirt Size: _____

Medical conditions/allergies/special needs: _____

Name: _____ Last grade completed: ___ Age: ___ Date of Birth: _____ Shirt Size: _____

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Medical conditions/allergies/special needs: _____

Children must be four years old by September 30, 2018

Fee enclosed (\$50 per child): _____ Make check payable to: Church of St. Clare

May we take pictures of your child for Vacation Bible School purposes? Yes ___ No ___

Signature of Parent/Guardian: _____ Date _____ E-Mail _____

Address: _____ City/Zip: _____ Home Parish: _____

Home: _____ Emergency phone number: _____

***** Medical Information & parent signature *MUST* be filled in on other side of this form *****



If you have any questions, would like to volunteer,
or need financial assistance please call Mrs. Mascia at 440-449-4242 ext 119.



All information is confidential. We believe no child should be deprived of this experience for financial reasons.

PART I OR II MUST BE COMPLETED

PART I (TO GRANT CONSENT)

In the event reasonable attempts to contact me at: () _____ or _____
(phone) (other parent)

at () _____ have been unsuccessful, I hereby give my consent for: (1) The administration
(other parent's phone)

of any treatment deemed necessary by Dr. _____, or Dr. _____ or in the
(dentist) (physician)

event the designated preferred practitioner is not available, by another licensed physician or dentist; and
(2) The transfer of the child to: _____ hospital or any hospital reasonably accessible. This
authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentist,
concurring in the necessity for such surgery, are obtained before surgery is performed.

Date: _____ Signature of Parent or Guardian: _____

PART II (REFUSAL TO CONSENT)

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

I do **Not** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring
emergency treatment, I wish the school authorities to take no action or to:

Date: _____ Signature of Parent or Guardian: _____

**It is also necessary for us to have the doctor's name and phone number. Please include this information
below:**

Doctor: Name: _____ Phone: _____

Dentist: Name: _____ Phone: _____

MUST BE COMPLETED:

RE: Privacy Act. It is understood that no student information will be given out without parental consent. However, we
wish to inform you that your name and home phone number will be given to selected adults who will keep the information
confidential and will use it only to inform you of emergency situations. If you have any problem with this policy, please
call me at (440) 449-4242 ext. 119.

I have read the above statement regarding the Privacy of Student Information.

Date: _____ Signature: _____