

- B R O S
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HOPE FELLOWSHIP C.R.C. STUDENT/YOUTH MINISTRY REGISTRATION FORM



PARTICIPANT'S INFORMATION

Last Name:		First Name:	
Middle Name:		Date of Birth: YYYY/MM/DD	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Current Address:			
City:	Province:	Postal Code:	
Phone:		Cell:	
Family Email Address:			
School Currently Attending:		Grade:	Church Currently Attending:

PARENT INFORMATION

Mother's Name:		Father's Name:	
Phone:	Cell:	Phone:	Cell:

EMERGENCY CONTACT

Name:	Relationship:
Phone:	Cell Phone:

PERSONS (OTHER THAN PARENTS) AUTHORIZED FOR PARTICIPANT PICK UP

Name:		Name:	
Relationship:	Phone:	Relationship:	Phone:

MEDICAL INFORMATION/HISTORY

Health Card #:	Doctor's Name:
Allergies? <input type="checkbox"/> NO, if <input type="checkbox"/> YES please describe:	
Medical Concerns? <input type="checkbox"/> NO, if <input type="checkbox"/> YES please describe:	
Other Related Concerns? <input type="checkbox"/> NO, if <input type="checkbox"/> YES please describe:	

USE OF IMAGE/INFORMATION CONSENT

As part of our activities, Hope Fellowship C.R.C. occasionally uses photography/video for publicity and informative purposes. In signing this form you permit Hope Fellowship C.R.C. and its programs to photograph/video your child for possible inclusion in their publications, website and other publicity related material. Please inform Hope Fellowship C.R.C. and its programs if you do not wish your child's image used, or name reproduced in any form. The personal information collected here may be shared with other Hope Fellowship C.R.C. programs. This information will not be distributed to any group outside of Hope Fellowship C.R.C. without your written consent.

INFORMED CONSENT/PARTICIPATION PERMISSION

Various programs may present various elements of risk. Incidents related to such activities may occur and cause injury, through no fault of any agents of Hope Fellowship C.R.C., or the facility at which the event occurred. You and your child must assume these risks. Hope Fellowship C.R.C. does not provide accidental insurance on behalf of its participants.

SIGNATURES

We verify that the information provided on this form is true and correct. We understand that it is our responsibility to inform Hope Fellowship C.R.C. and its programs of any change to the information on this form. We understand that if we do not, it may result in removal from the program and/or pose a possible liability/safety concern.

Signature of participant:	Date: YYYY/MM/DD
Signature of parent Or legal guardian:	Date: YYYY/MM/DD