



St. Mary & St. Patrick Church

2018 Vacation Bible School

VOLUNTEER REGISTRATION FORM

We need you!!!

NAME _____

(PLEASE PRINT)

ADDRESS _____

STREET

CITY

STATE

ZIP CODE

HOME PHONE # _____ CELL # _____

EMAIL: _____

(PLEASE PRINT CLEARLY)

ADULT / TEEN **IF TEEN, LAST SCHOOL GRADE COMPLETED** _____

(CIRCLE ONE)

BEST TIME TO REACH ME: AM / PM (CIRCLE ONE)

MY AREA OF INTEREST IS:

Must be 12 years of age or older at the time of VBS and must be available all 5 days

from 8:30 AM - 1:00 PM for the positions listed

____ CREW LEADER (Guides a crew of 5 to 6 children from station to station)

____ BIBLE THEATER

____ KITCHEN

____ REFLECTION

____ CRAFTS

____ MUSIC & SKITS

____ VIDEO PRODUCTION

____ GAMES

____ PHOTOGRAPHER

____ I CAN HELP WHERE NEEDED

____ I AM SORRY, I AM UNABLE TO COMMIT FOR 5 DAYS BUT I WOULD STILL LIKE TO HELP

____ PLEASE FEEL FREE TO CONTACT ME AND I WILL PURCHASE SUPPLIES

IF YOU HAVE QUESTIONS, PLEASE CONTACT

ST. PATRICK RELIGIOUS EDUCATION OFFICE (815) 385-2959

bcurry@stpatrickmchenry.org



2018 Vacation Bible School

Medical Permission Form

Please complete one form for each volunteer

I grant permission for the administration of first aid to _____

By the people in charge of St. Patrick/St. Mary Vacation Bible School and those transporting my child to and from the program as their judgement deem advisable, and to make the necessary referrals to qualified physicians for the treatment of illness or accidents of a more serious nature. I understand that I will be promptly notified in the event of any serious illness or accident and prior to any surgery, except when delay in such communication would endanger a life. In case of medical emergency, I understand that every effort will be made to contact the parents/guardian to the participant. In the event I cannot be reached I hereby give permission to the physician selected by the adult staff to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery, if deemed as necessary for my child. I, the undersigned, shall be liable and agrees to pay all cost and expenses incurred in connection with such medical and dental rendered to the aforementioned child pursuant to this authorization.

Should it be necessary for my child to return home due to medical reasons or discipline problems, the undersigned will be called and expected to pick up the child or make arrangements for the child to be picked up immediately.

Printed name of Parent or Guardian _____

Signature of Parent or Guardian _____ Date _____

In case of custody agreement, permission form must be signed by parent who has custody on these days.

Address _____

City, State, Zip _____

Authorized Physician _____ Phone _____

Insurance Information

Policy in name of _____

Insurance Company _____

Group # _____ ID# _____