

**Camp E.D.G.E.**  
**Vacation Bible School Registration Form**  
**Asbury United Methodist Church**  
**July 27 to 31, 2009**  
**9:00 a.m. to Noon**



**This registration is for:**

- Student  
 Youth Helper  
(Completed 6th grade or older)

**Cost:** \$10 per child, \$25 for family  
No fee for youth helpers.  
Financial aid is available,  
contact Mitchie McCammon.

Name: \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home telephone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Home e-mail address: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Last school grade completed: \_\_\_\_\_

In case of emergency, contact: \_\_\_\_\_

Mother's name: \_\_\_\_\_ day telephone: \_\_\_\_\_

Father's name: \_\_\_\_\_ day telephone: \_\_\_\_\_

Allergies or other medical conditions: \_\_\_\_\_

Home church: \_\_\_\_\_

Who will be picking up child after VBS? Name: \_\_\_\_\_ phone: \_\_\_\_\_



**Contacts:**

Mitchie McCammon 447-1950 x 5  
MitchieM@asburylive.org  
Kellie Campos 606-7125

Medical Release Form  
SonWorld Adventure VBS 2008

I (We), the undersigned parent(s) or guardian(s) of \_\_\_\_\_, a minor, do hereby authorize adult volunteers of Asbury United Methodist Church as agent(s) for the undersigned, to consent to any medical or surgical care deemed advisable by any accredited physician or surgeon in an approved emergency clinic or hospital. I further hereby give my approval of, and consent to him/her to participate in any and all of the activities of VBS. I assume all risks and hazards incidental to the activities, and so hereby release, acquit, and forever discharge and agree to indemnify and save harmless Asbury United Methodist Church, their VBS, their instructors and supervisors, and all other persons assisting with the conduct of said activities. This agreement does not apply to claims for intentional misconduct or gross negligence.

Date signed \_\_\_\_\_

Parent/Legal Guardian (Print) \_\_\_\_\_

Parent/Legal Guardian (Sign) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

Emergency Phone: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Health Insurance Company \_\_\_\_\_

Policy or Group Number \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

If parent/legal guardian is not available in an emergency, contact

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Please list any allergies. Include medications, food, and etc. \_\_\_\_\_

Does your child have any medical or special needs, including medications currently being used? No \_\_\_\_\_ Yes \_\_\_\_\_ If so, please explain. \_\_\_\_\_

Doctor's Name \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Dentist's Name \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Date of last tetanus \_\_\_\_\_

Birth date \_\_\_\_\_