# Parent's Night Out Registration Form

**Birth – 5th Grade**

**Friday, February 15, 5:30-8:30 PM**

*Cost is $20.00 per child, $50.00 family max. Cash or check may be paid beforehand at church office or day of event.*

Child(ren)'s name(s) with Age(s):_____

_____

Name of parent(s): _____

Street address: _____

Primary Phone: _____ Secondary Phone:_____

Email address: _____

Persons authorized to pick up children: _____

Allergies or other medical conditions: _____

****You must complete an Emergency Medical Authorization Form for <u>each child</u>.****

**Once completed, return completed forms to the Welcome Center, the Church Office, or to tlong@baysidebc.org**

**For office use only:**

Amount owed: _____

Amount paid: _____

Method of payment: _____

# Parent's Night Out
# Child Emergency Medical Authorization

Friday, February 15, 2018 5:30-8:30pm

*****Please complete a separate form for each child*****

**Child's Name** _____

**Other siblings attending this event:** _____

**Parents Name:** _____
**Phone #:** _____ **Cell phone #:** _____

**Alternate emergency contact Name & Phone #:** _____

The Parent(s)/ guardian authorize **Bayside Baptist Church Adult Leadership** to obtain immediate medical care should an emergency or accident occur requiring medical treatment for my child on **Friday, February 16, 2018**. This document shall serve as my authorization for the emergency medical physician to perform necessary diagnostic test, administration of drugs, the use of surgery or other procedures deemed necessary if an emergency occurs and the parent/guardian cannot be located. Further, I acknowledge my financial responsibility for any treatment rendered in such an emergency. It is understood that this agreement covers only those situations that are true medical emergencies and only when the parent/guardian cannot be reached.

I understand and agree that Bayside Baptist Church and the group leaders are not liable for any claims of injury, sickness, death, or personal property damage that occur during activities that are scheduled and conducted according to the church's bylaws and lawfully chaperoned, or when such claims are a direct result of my child's actions or choices while reasonably supervised.

1. I/we will be responsible for payment of medical expenses

   Name: _____

2. Medical treatment cost are covered by: (Please attach a copy of your insurance card)

   Name of Insurance: _____

   Policy #: _____

Any allergies to food, drugs, etc.: _____

Other conditions we need to be aware of: _____

**Parent(s)/Guardian signature:** _____ **Date:** _____