

VBS CHILD ENROLLMENT
St. John's Lutheran Church: VBS Special Edition



Location: The Special Learning Center
1115 Fairgrounds Rd.
Jefferson City, MO 65109

RETURN FORM TO: St. John's Lutheran Church, 4409 St. John's Road, Jefferson City, MO 65101
or VIA EMAIL: vbsstjohns@gmail.com
(Also, can return form to Special Learning Center)

CHILD'S NAME:		SEX:	BIRTHDATE:
ADDRESS: Street: City/State/Zip:		HOME PHONE NUMBER ()	
FAMILY INFORMATION			
NAME of PARENTS / GUARDIANS:		HOME PHONE NUMBER: ()	
E-MAIL ADDRESS:		CELLPHONE NUMBER: ()	
ADDRESS (IF DIFFERENT FROM CHILD'S ABOVE) Street: City/State/Zip:		WORK or OTHER TELEPHONE NUMBER: ()	
Home Church:			
* NAME OF PERSON TRANSPORTING (IF NOT A PARENT LISTED ABOVE):			
CELLPHONE NUMBER: ()		ADDRESS (IF DIFFERENT FROM CHILD'S ABOVE) Street: City/State/Zip:	
EMERGENCY CONTACTS (OTHER THAN PARENTS OR DOCTOR) – (AT LEAST ONE EMERGENCY CONTACT IS SUGGESTED)			
NAME OF EMERGENCY CONTACT:		TELEPHONE NUMBER: ()	
ADDRESS (STREET, CITY, STATE, ZIP CODE)		RELATIONSHIP	
Optional	NAME OF EMERGENCY CONTACT:		TELEPHONE NUMBER: ()
	ADDRESS (STREET, CITY, STATE, ZIP CODE)		RELATIONSHIP

(Please complete both pages & Return prior to the first day, if possible)

NAME of CHILD:

PERSON(S) AUTHORIZED TO PICK UP CHILD:

Name:

Name:

Phone:

Phone:

SPECIAL CONCERNS OR CONSIDERATIONS:

Allergies:

Please list anything else you would like us to know about your child:

AUTHORIZATION FOR EMERGENCY MEDICAL CARE:

I understand that I will be notified at once in case of accident or illness to my child and that I will make arrangements for medical care of my child with the physician or hospital or my choice.

If I cannot be reached to make the necessary arrangements or in a critical emergency requiring medical care, I hereby authorize St. John's Lutheran Church to contact:

(Please list the name/phone number of doctor, hospital OF YOUR CHOICE or both.)

Name of Doctor/Clinic:

Phone:

Office Address:

HOSPITAL preference (please circle one) : Capitol Region / St. Mary's / (EITHER)

SIGNATURE OF PARENT / GUARDIAN: _____

Date:

*RETURN FORM TO: St. John's Lutheran Church, 4409 St. John's Road, Jefferson City, MO 65101
or VIA EMAIL: ybstjohns@gmail.com (Also, can return form to Special Learning Center)*

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