



Shiloh Family Ministry Parents' Night Out Registration

Children 6 weeks - 5th grade

Registration Deadline is 11-25-18, or when spaces are full.

**Event is
November 30,
6:00 - 8:30**

Parent/Guardian Name: _____

E-mail: _____

Best Phone number: (____) _____

Office Use Only	Number of children attending: _____
	Cost: _____ (\$10 per child; max \$30 per family)
	Method Paid: ___ cash ___ check (#) _____
	Received by: _____ Date Received: _____ Number received: _____

Child's Name	Gender	Age	D.O.B.	Grade	Allergies

Address:

_____ street _____ city _____ state _____ zip

For emergency contact the night of PNO:

Phone: (____) _____ **Name** _____ **Relationship to child(ren):** _____

Phone: (____) _____ **Name** _____ **Relationship to child(ren):** _____

Permission

I give permission for my child(ren) to participate in Parents' Night Out. I and my child hereby knowingly and freely waive any and all causes of possible action and liability, etc. which I and my child have or acquire against Shiloh United Methodist Church, its Children's Ministry (including Shiloh Preschool), its Leadership Board, employees, and volunteers/servants. I hereby agree that as long as the Shiloh United Methodist Church Children's Ministry, its employees and its volunteers/servants act in a reasonable and responsible manner, my child and I will not hold them responsible for any consequences that may arise related to this event.

I understand that spaces are limited for this event, and they are filled on a first-come (registered/paid), first-served basis.

I agree. I do not agree. **Parent initials:** _____

Photo Consent: I agree to allow Shiloh UMC to use photos, video, and sound recordings of my child(ren) as part of its news and publicity about Shiloh's ministries, which I understand may include

Mailings News articles Website postings

I understand Shiloh will never use my child(ren)'s last name(s) or address without my further authorization.

I agree. I do not agree. **Parent initials:** _____

Medical Consent: By signing, I consent to any necessary examination, anesthetic, medical diagnosis, surgery or treatment and/or hospital care rendered to my child(ren) under special supervision and on the advice of any physician licensed to proactive medicine by the state in which they practice during the church event.

I agree. I do not agree. **Parent initials:** _____

Parent/Guardian Name Printed: _____ **Signature:** _____ **Date:** _____

Shiloh 2018/2019
Medical Release Form

Purpose - To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under the church authority, when parents or guardians cannot be reached.

Child's Name	Being treated for these medical conditions	Taking these prescription drugs

Address: _____

City, State, Zip: _____

Parent or Guardian

Mother: _____ Cell Phone: _____

Father: _____ Cell Phone: _____

Other: _____ Cell Phone: _____

House/Work Phone(s): _____

Participant's Physician: _____ Phone: _____

Participant's Dentist: _____ Phone: _____

Participant's Medical Insurance

Carrier: _____ Policy number: _____

Please provide a copy of the front and back of your medical insurance card.

Emergency contact

Name: _____ Relationship: _____

Address, City, State, Zip: _____

Home phone: _____ Bus. Phone: _____

Please initial one of these choices:

___ *I request Shiloh UMC keep this form and medical card on file for one year.*

___ *Please shred after event and I will fill out a new release form for the next event.*

Parent/Guardian Signature: _____ **Date:** _____

