WSM CONTACT INFO FORM

2010-2011 SCHOOL YEAR

FULL NAME: _____ GENDER: M F

AGE: 11 12 13 14 15 16 17 18 GRADE: 6 7 8 9 10 11 12

BIRTHDAY:

JAN FEB MAR APR MAY JUN JUL AUG SEPT OCT NOV DEC

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

ADDRESS, INCLUDING CITY AND POSTAL CODE:

_____

_____

HOME PHONE: _____

PARENTS' CELL PHONE: _____

STUDENT'S CELL PHONE: _____

PARENTS' EMAIL ADDRESS(ES): _____

STUDENT'S EMAIL ADDRESS: _____

NOTE: MOST CONTACT WILL BE VIA EMAIL - PLEASE CHECK YOUR EMAIL REGULARLY AND CHECK TO ENSURE THAT EMAILS FROM YOUTH@WESTHEIGHTS.ORG GET THROUGH YOUR SPAM FILTER. PLEASE ALSO CHECK WSM.WESTHEIGHTS.ORG OFTEN. THANK YOU!

OHIP #: _____

FAMILY PHYSICIAN'S NAME AND PHONE NUMBER: _____

FAMILY DENTIST'S NAME AND PHONE NUMBER: _____

EMERGENCY CONTACT INFORMATION: _____

ALLERGY, HEALTH OR OTHER INFORMATION WE SHOULD BE AWARE OF:

_____

_____

_____

PARENT/GUARDIAN AGREEMENT

PRECAUTIONS ARE TAKEN FOR THE SAFETY AND HEALTH OF YOUR CHILD, BUT IN THE EVENT OF ACCIDENT OR SICKNESS, WESTHEIGHTS COMMUNITY CHURCH, ITS STAFF, AND ITS VOLUNTEERS ARE HEREBY RELEASED FROM ANY LIABILITY. IN THE EVENT THAT YOUR CHILD REQUIRES SPECIAL MEDICAL ATTENTION, X-RAYS OR TREATMENT, PARENTS/ GUARDIANS WILL BE NOTIFIED IMMEDIATELY.

I GIVE MY PERMISSION FOR MY CHILD TO TAKE PART IN WESTHEIGHTS STUDENT MINISTRIES YOUTH EVENTS DURING THE 2010-2011 SCHOOL YEAR AND PARTICIPATE IN ALL GROUP ACTIVITIES. IN CASE OF SURGICAL EMERGENCY, I HEREBY GIVE PERMISSION TO THE PHYSICIAN SELECTED BY THE CHURCH TO HOSPITALIZE, SECURE PROPER TREATMENT FOR, AND TO ORDER INJECTION, ANESTHESIA OR SURGERY FOR MY CHILD AS NAMED ON THE REVERSE OF THIS FORM.

SIGNATURE OF PARENT/GUARDIAN: _____

DATE SIGNED: _____