

# SonRise Castle



## Vacation Bible School Registration 2010

Child's Name: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Grade (Fall 2010): \_\_\_\_\_

Who has permission to pick my child up from VBS? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

We are so excited to have your child at VBS. There will be classes for Rising K4 – 6<sup>th</sup> grade. Please fill out these forms and return them to the church office by **Monday, July 19<sup>th</sup>**.

If you have any questions please contact Danyelle Blich 559-5456

[danyelleblitch@gmail.com](mailto:danyelleblitch@gmail.com) or Paige Thorn 762-1164 [pht@paigehathawaythorn.com](mailto:pht@paigehathawaythorn.com).

# St. John's Parish Permission Form and Release Statement

I hereby give permission for \_\_\_\_\_ to attend St. John's Parish activities, events, and retreats, including those sponsored and supervised off-site, and participate in its activities for the period July 1, 2010 through June 30, 2011. I also give my permission for St. John's staff and volunteer leaders to obtain emergency medical treatment to be administered to my child. I understand that an attempt will be made to contact me in the event of an emergency. I hold harmless St. John's Parish and the Episcopal Diocese of South Carolina and the staff and leaders involved in church sponsored activities.

## Videotaping and Still Photographs

I authorize St. John's Parish to use photographs and videos of my child for productions, publications, etc. which are exclusively for the purpose of promoting activities related to St. John's Parish.

Guardian Name (print) \_\_\_\_\_ Date \_\_\_\_\_

Guardian Signature: \_\_\_\_\_

Day Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Alternate Emergency Contact \_\_\_\_\_

Relation \_\_\_\_\_ Phone \_\_\_\_\_

Medical Insurance Company \_\_\_\_\_

Id/Group Number \_\_\_\_\_ Insurance Co. Phone # \_\_\_\_\_

Allergies (food, medicines, materials such as latex): \_\_\_\_\_

Please list any medications the student is taking and what they are treating:

\_\_\_\_\_ for \_\_\_\_\_

\_\_\_\_\_ for \_\_\_\_\_

\_\_\_\_\_ for \_\_\_\_\_

Personal Doctor \_\_\_\_\_ Doctor's Number \_\_\_\_\_

Other information \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(HIPPA Form)

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Participant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address : \_\_\_\_\_

Phone: (home) \_\_\_\_\_ (alternate) \_\_\_\_\_

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The purpose of this disclosure is to facilitate the treatment of the participant in the event of a medical emergency while participating in a St. Johns Parish sponsored activity for the period July 1, 2010 through June 30, 2011.

The type of information to be disclosed is as follows:

- |                      |                    |                                |
|----------------------|--------------------|--------------------------------|
| problem list         | medications        | physician progress/visit notes |
| radiological reports | nurse notes        | physician orders               |
| films/images         | laboratory results | discharge summary              |

**I understand this information may include reference to physical and psychiatric care.**

**I authorize the exchange of this information via phone, email, fax, or face to face.**

I understand that I have a right to cancel/revoke this authorization at any time. I understand that if I cancel/revoke this authorization I must do so in writing and present my written cancellation/revocation to St. Johns Parish. I understand that the cancellation/revocation will not apply to information which has already been released in response to this authorization. This authorization will expire when the participant is in my physical custody.

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this authorization in order for the participant to receive treatment. I understand that I may review and/or copy the information disclosed. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person/ organization receiving the information. If I have questions about the disclosure or use of this participant's protected health information I may contact St. Johns Parish at 559-9560.

*I understand that I will be given a copy of this authorization upon request.*

\_\_\_\_\_  
Signature of Participant or Legal Guardian

Date: \_\_\_\_\_

\_\_\_\_\_  
Printed Name of Participant or Legal Guardian

\_\_\_\_\_  
Relationship to Participant if Signed by Legal Guardian

\_\_\_\_\_  
Witness Signature

Description of Participant's Representative's authority (Why participant is not signing): Participant is a minor.