

SOUTH CENTRAL REGIONAL TRAINING INSTITUTE

Arkansas • Louisiana • Oklahoma • Texas



PARTICIPANT REGISTRATION FORM

PARTICIPANT'S INFORMATION

Name: _____ Home Phone #: _____

Address: _____

Student's Age: _____ Grade Level: _____ Birth Date: ____ / ____ / ____

PARENT/GUARDIAN'S INFORMATION

Name: _____ Day Phone #: _____ Email: _____

Name: _____ Day Phone #: _____ Email: _____

Who is authorized to pick your child/youth up from his or her activity? If you only wish for specific individuals to pick your child or youth up, please list their name below. Otherwise, any authorized supervisor of the activity may be called upon to assist. *(Only those individuals listed below will be allowed to pick your child/youth up after his or her activity)*

Children's class teacher _____

Junior Youth Group Animator (mentor) _____

Study Circle Tutor (facilitator) _____

MEDICAL RELEASE FORM

I, the undersigned parent or guardian of _____, a minor, do hereby authorize the South Central Regional Training Institute or its designated representative, agent(s) for the undersigned, to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the Medicine Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. As the parent/guardian of a minor under the age of 18, I understand that this authorization enables the South Central Regional Training Institute to arrange medical care for my dependent minor in the event I am unavailable.

I understand that I am responsible for payment of any and all medical expenses incurred on behalf of my dependent minor. This authorization shall remain effective from ____/____/____ [date] for up to a year unless specified, while my child is attending South Central Regional Training Institute activities.

Parent/Guardian Signature: _____ Date: ____ / ____ / ____

Emergency Contact Name and Telephone: _____

Family Physician Name and Telephone: _____

Medical Insurance Company: _____

Policy Number: _____

Additional Emergency Contact (in the event parent cannot be reached): _____

Telephone #: (____) _____ — _____



MEDICAL RELEASE FORM (CONTINUED)

List Allergies, Handicaps, Limiting Health Conditions, Medications, Reactions to Medications:

TRANSPORTATION CONSENT AND PHOTO CONSENT AGREEMENT

I hereby *consent* / *decline* (circle one) to authorize the use of and reproduction of any and all photographs and any other audiovisual materials taken of the registered individuals listed above for inclusion in any of the program's promotional printed material, websites and online social media platforms, for the purposes of the promotion of the program.

By signing below, I further *consent* / *decline* (circle one) to authorize the class teachers, leaders or their assistants who are 18 years old or older, to transport my children to and from class in a vehicle or other means as necessary.

Parent/Guardian Signature: _____ Date: ___ / ___ / ___