

# WNL! Registration Form 2011-12

**Child's Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Phone #:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Grade:** \_\_\_\_\_  
**Parent(s) Name:** \_\_\_\_\_  
**E-Mail Address(s):** \_\_\_\_\_  
**Parent(s) Alternate Phone #(s):** \_\_\_\_\_  
**Alternate Contact:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_  
**Alternate Contact Phone #(s):** \_\_\_\_\_

I hereby certify that I am the legal guardian of the above named child and I hereby grant permission for him/her to participate in all church related activities of the First Presbyterian Church of Canyon, Texas. I hereby grant permission to transport him/her while participating in all church related activities of the First Presbyterian Church.

I do hereby release from all liability and covenant not to sue and do hereby agree to hold harmless and indemnify First Presbyterian Church and its representatives from any and/or all claims of injury or illness, which may be sustained by my child. I authorize those representatives or their designee to select medical facilities and/or physician and authorize treatment for my child in the event that such treatment should become necessary. I further acknowledge that I am responsible for health insurance and/or payment of any and all expenses that may be incurred for said medical treatment for my child.

Signature of parent or guardian: **X** \_\_\_\_\_

**Child's Name:**

**Age:                      Grade:                      Date of Birth:**

<b>1</b>	<input type="text"/>	8/31/2011	<b>11</b>	<input type="text"/>	11/9/2011	<b>21</b>	<input type="text"/>	2/15/2012
<b>2</b>	<input type="text"/>	9/7/2011	<b>12</b>	<input type="text"/>	11/16/2011	<b>22</b>	<input type="text"/>	2/22/2012
<b>3</b>	<input type="text"/>	9/14/2011	<b>13</b>	<input type="text"/>	11/30/2011	<b>23</b>	<input type="text"/>	2/29/2012
<b>4</b>	<input type="text"/>	9/21/2011	<b>14</b>	<input type="text"/>	12/7/2011	<b>24</b>	<input type="text"/>	3/7/2012
<b>5</b>	<input type="text"/>	9/28/2011	<b>15</b>	<input type="text"/>	1/4/2012	<b>25</b>	<input type="text"/>	3/14/2012
<b>6</b>	<input type="text"/>	10/5/2011	<b>16</b>	<input type="text"/>	1/11/2012	<b>26</b>	<input type="text"/>	3/28/2012
<b>7</b>	<input type="text"/>	10/12/2011	<b>17</b>	<input type="text"/>	1/18/2012	<b>27</b>	<input type="text"/>	4/4/2012
<b>8</b>	<input type="text"/>	10/19/2011	<b>18</b>	<input type="text"/>	1/25/2012	<b>28</b>	<input type="text"/>	4/11/2012
<b>9</b>	<input type="text"/>	10/26/2011	<b>19</b>	<input type="text"/>	2/1/2012	<b>29</b>	<input type="text"/>	4/18/2012
<b>10</b>	<input type="text"/>	11/2/2011	<b>20</b>	<input type="text"/>	2/8/2012		<input type="text"/>	

**Insurance Company:** \_\_\_\_\_ **Policy/Group #:** \_\_\_\_\_

**Physician:** \_\_\_\_\_ **Physician's Phone #:** \_\_\_\_\_

**Known medical conditions or pharmaceutical allergies:**

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