

ADVENTURE CLUB

February 8 - May 8
2012

WEDNESDAY NIGHTS
6:30 - 8:00

FOR CHILDREN AGES 3 Years old - 5TH GRADE

CHILD'S NAME: _____

PARENT'S NAME: _____

ADDRESS: _____

E-MAIL ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____

CHILD'S AGE _____ GRADE _____

ADVENTURE CLUB IS PRIMARILY A VOLUNTEER RUN ACTIVITY AND WE CAN ALWAYS USE VOLUNTEERS.

IF YOU WOULD BE INTERESTED IN VOLUNTEERING PLEASE CALL CAROL AUBREY AT 561-364-5840

PLEASE ENCLOSE PAYMENT OF \$30.00 FOR THE 13 WEEK SESSION.
CHECKS SHOULD BE MADE PAYABLE TO: FAITH UNITED METHODIST CHURCH
DROP OFF IN CHURCH OFFICE, GIVE TO CAROL AUBREY, OR MAIL TO:
6340 W. BOYNTON BEACH BLVD. BOYNTON BEACH, FL 33437

ALL FEES ARE NON-REFUNDABLE

PLEASE COMPLETE MEDICAL RELEASE ON THE BACK SIDE OF THIS FORM.

THE CHILDREN'S MINISTRY NOW HAS AN EMAIL NEWSLETTER. IF YOU DO NOT ALREADY RECEIVE THE NEWSLETTER AND WOULD LIKE TO PLEASE INDICATE BELOW:

YES, PLEASE SEND ME THE NEWSLETTER AT THE FOLLOWING EMAIL ADDRESS:

Medical Release Form

Date: _____
Child's Name: _____ Male () Female () Age: _____ Birth Date: _____
Parent's Names: _____
Address: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Emergency Contacts: (must list two)

1. Name: _____ Relationship: _____ Phone Number: _____

2. Name: _____ Relationship: _____ Phone Number: _____

ARE THERE ANY MEDICAL RESTRICTIONS? YES () NO ()

If yes, please explain:

Allergies: _____

I _____, the legal parent or guardian of _____ (name of child)

Do give permission for Faith United Methodist Church/Representative to render or seek
Medical care for my child in the event of an emergency where such care is needed.

Signature: _____ Date: _____

I _____, the parent or legal guardian of _____ do recognize that
participation in this program is voluntary and at the participant's own risk. Therefore I release
from liability for injuries sustained by my child, not due to willful or malicious neglect, Faith United
Methodist Church, it's pastors, staff and volunteers.

Signature: _____ Date: _____