COMPASSION KIDS

- ☐ First Time Attending
- ☐ New Addition to Your Family
- ☐ Update to Your Information
- ☐ Guest with Your Family

By completing this form I, or the person bringing the child(ren) listed, agree to stay on campus during all Kids Programming

Child Information

FIRST NAME	LAST NAME	M/F	DOB	AGE	GRADE	ALLERGIES/SPECIAL NEEDS/ CUSTODY NOTES *(AUTISM, ASTHMA, HEARING IMPAIRED, ETC.)*
		M/F	/ /			
		M/F	/ /			
		M/F	/ /			
		M/F	/ /			

Responsible Party Information

1ST ADULT FIRST NAME	LAST NAME	RELATIONSHIP TO CHILD (CIRCLE ONE) MOTHER / FATHER / GUARDIAN / OTHER	DOB / /
CELL PHONE		EMAIL	
1ST ADULT FIRST NAME	LAST NAME	RELATIONSHIP TO CHILD (CIRCLE ONE) MOTHER / FATHER / GUARDIAN / OTHER	DOB / /
CELL PHONE		EMAIL	

ONLY COMPLETE THE FOLLOWING SECTION IF YOU ARE THE PARENT OR GUARDIAN

FAMILY ADDRESS	CITY	STATE	ZIP

FULL NAME OF OTHER ADULT(S) ALLOWED TO PICK UP CHILD(REN)	RELATIONSHIP	DOB	CELL PHONE
		/ /	
		/ /	

The information contained herein is true and correct to the best of my knowledge. All consents and authorizations shall remain in effect unless revoked in writing by the undersigned to Compassion Christian Church, 55 Al Henderson Blvd., Savannah, GA 31419.

MEDICAL AUTHORIZATION/ CONSENT FOR MEDICAL TREATMENT OF A MINOR

I recognize that there may be occasions where any one or more of the minor children named above are in need of first aid or emergency medical or dental treatment as a result of an accident, illness, or other health condition or injury, and I am not available to make health care decisions for said child(ren). Under such circumstances, I here-by give permission for a Staff Member and/or Volunteer of Compassion Christian Church, to provide first aid care to said child(ren) named above. Furthermore, in the event my child(ren) are in need of emergency medical or dental care, I authorize Compassion Christian Church, Inc. or their designated representative to transport my child(ren) to the emergency room of a licensed hospital, and I hereby grant my consent for the hospital and its medical staff to provide my child(ren) with emergency medical treat-ment which a licensed physician deems necessary (including anesthesia). I agree to accept financial responsibility for all transportation, hospital, medical, and other ex-penses incurred.

As a parent or legal guardian of my minor child (Participant named above), I am responsible for the health care decisions of my minor child and am authorized to consent to the services to be rendered. I represent that my consent to and agreement to pay for dental, medical, and/or hospital care or treatment to be rendered to my minor child is legally sufficient and that no consent from any other person is required.

PRINTED NAME OF PARENT/GUARDIAN _____

SIGNATURE OF PARENT/GUARDIAN _____ **DATE** _____