St. James Catholic Church
605 S. Alta Vista St.
Beeville,Tx 78102
Phone: 361-358-4825
Email drestjamesbeeville@yahoo.com

Complete & return this form to the Parish Office by July 27th
Vacation Bible School (VBS) will begin on Friday, August 4th at 5:30pm and end on Sunday, August 6th at noon.

TUITION & FEES: FREE

1. FAMILY INFORMATION **New families are asked to submit a copy of each child's Baptism certificate along with this form.

Child/ren's Last Name:	
Primary Mailing Address:	
City, State, Zip:	
Mother's Name:	Contact #:
Father's Name	Contact #:

2. STUDENT INFORMATION If more than 3 children, please use an additional form

	Child # 1	Child # 2	Child # 3
First and Middle Name			
Gender	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female
Date of Birth: *mm/dd/yy*			
Special Needs / Allergies Information:			
Religious Education Level for **2023-2024 school year**	*Please circle ONE:* 1, 2, 3, 4, 5, 6, 7, 8 9, 10, 11, 12	*Please circle ONE:* 1, 2, 3, 4, 5, 6, 7, 8 9, 10, 11, 12	*Please circle ONE:* 1, 2, 3, 4, 5, 6, 7, 8 9, 10, 11, 12
Session times and days:	**Friday: 5:30pm-8:30pm** **Saturday: 10:00am-3:30pm** **Sunday: 8:00am-noon**	**Friday: 5:30pm-8:30pm** **Saturday: 10:00am-3:30pm** **Sunday: 8:00am-noon**	**Friday: 5:30pm-8:30pm** **Saturday: 10:00am-3:30pm** **Sunday: 8:00am-noon**
T-Shirt Size:			

MEDICAL CONSENT
Please complete one per child/teen

Medical Matters
I hereby warrant to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child. Of the following statements pertaining to medical matters, sign only those in accordance with your wishes:

Emergency Medical Treatment
In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor.

In the event of an emergency and you are unable to reach me, contact:

Name & Relationship _____ Phone_____

Medications:

Family Doctor _____Phone_____

My child will bring all such medications, well labeled, that are necessary. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency are as follows:

Medication(s):_____Dosage: _____
Administer: _____

_____I hereby **Do Not Grant Permission** for medication of any type, whether prescription or nonprescription may be administered by my child unless the situation is life threatening and emergency treatment is required. (Please initial)

_____I hereby **Grant Permission** for nonprescription medication (such as Tylenol, throat lozenges, cough syrup) to be given to my child, if deemed advisable. I understand that Aspirin will not be given to my son/daughter. (Please initial)

Medical Conditions Information

(Diocesan personnel will take reasonable care to see that the following information will be held in confidence.)
My son/daughter has had an episode ofthe following or has been diagnosed: ☐Siezures Asthma ☐ Diabetic
Allergic reactions to the following (foods, dyes, latex etc.) _____
Has had a medical surgery within the last six months? Yes No Still under doctor's care? Yes No
Has a medically prescribed diet? _____
The following physical limitations? _____
Immunizations current and up to date: Yes No Date of last tetanus/diphtheria immunization _____
You should also be aware of these special medical conditions of my child: _____

Insurance Information

(Please attach a copy of the Insurance Card, front and back, with this form)

Insurance Carrier: _____
Name of Insured: _____
Insurance Policy Number: _____

Father's Name:_____ Day Phone: _____

Mother's Name:_____ Day Phone: _____

____No, I do not carry medical insurance at this time.

In the event it comes to the attention of the chaperones associated with the activity that my child becomes ill with repeated symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called immediately. If this will be a long distance call, I want to be called collect (with phone charges reversed to myself).

I fully understand the foregoing statements and sign this Parental/Guardian Medical Consent Waiver knowingly, freely, and willingly.

_____ _____
Signature (Parent/Guardian) **Date**

_____ _____
Signature (Participant 18 years of age or older must signown consent) **Date**