

# The Chronicles of Narnia



## Sonburst 2009 Registration Form

### Children's Information:

1. Name: \_\_\_\_\_ Sex: M\_\_ F\_\_ Age: \_\_\_\_  
Birth Day \_\_/\_\_/\_\_ Health Card #: \_\_\_\_\_

2. Name: \_\_\_\_\_ Sex: M\_\_ F\_\_ Age: \_\_\_\_  
Birth Day \_\_/\_\_/\_\_ Health Card #: \_\_\_\_\_

3. Name: \_\_\_\_\_ Sex: M\_\_ F\_\_ Age: \_\_\_\_  
Birth Day \_\_/\_\_/\_\_ Health Card #: \_\_\_\_\_

4. Name: \_\_\_\_\_ Sex: M\_\_ F\_\_ Age: \_\_\_\_  
Birth Day \_\_/\_\_/\_\_ Health Card #: \_\_\_\_\_

\$35 per child = Total Due: \_\_\_\_\_

Church Affiliation: \_\_\_\_\_

### Parent/Legal Guardian's Information:

Names(s) \_\_\_\_\_  
Address \_\_\_\_\_

Home Phone # \_\_\_\_\_ Day-Time Phone # \_\_\_\_\_

Alternate Contact Person \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Day-Time Phone # \_\_\_\_\_

**Medical Information:**

Please indicate if any of the campers listed above are taking any medications or if they have any allergies in the space provided:

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Please indicate if there are any other medical conditions we should be aware of (i.e. asthma, epilepsy, diabetes etc...) Y \_\_ N \_\_ If yes, please elaborate:

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**Disclaimer:**

I the parent or legal guardian of the SonBurst participant(s) listed on this form, certify that she/he has my full approval to participate in SonBurst. The child(ren) identified on the form understands that all participants are expected to abide by the rules set forward by the leadership of this program, and are to be directly responsible to them. Further I do release and hereby agree to hold blameless St. Thomas Christian Church, Mapleton Church of Christ (Disciples of Christ), SonBurst, and the employees, volunteers and agents of both, from any and every claim arising or which may be asserted by me or by any member of my family by reason of participating in any activities associated with SonBurst. Further, I do authorize the Director or sponsor of this activity, in the event I cannot be reached by phone, to give consent to a medical physician and/or hospital for any emergency treatment. It is understood that I will assume any financial responsibility for any expense that may be incurred for said treatment. Further, I do certify that said child(ren) is covered by adequate medical insurance. My consent and signature is given below. I have read and agreed to the information in this entire form.

\_\_\_\_\_  
Name of Parent/Legal Guardian

\_\_\_\_\_  
Date

Note: If Family Members can help (especially during the lunch hour) please sign and indicate time and day:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
Time & Day available

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For use by Registrar

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