

**FBC SWAINSBORO WEDNESDAY NIGHT PROGRAM
INFORMATION SHEET**

NAME _____ AGE _____ BIRTHDATE _____
(MM/DD/YR)

STREET ADDRESS _____ CITY/ST/ZIP _____

MAILING ADDRESS (if different from above) _____

GRADE & SCHOOL: _____

PARENT/GUARDIAN

Name: _____ Preferred Phone: _____ Alt. Phone: _____

Email: _____@_____.

STREET ADDRESS _____ CITY/ST/ZIP _____

MAILING ADDRESS (if different from above) _____

Please list the names of two adults other than parent/guardian who may be contacted in case of emergency.

Name: _____ Preferred Phone: _____ Alt. Phone: _____

Name: _____ Preferred Phone: _____ Alt. Phone: _____

MEDICAL CONDITION

Does your student suffer from, or has he/she ever experienced or been treated for any of the following:

- Asthma frequently upset stomach epilepsy/seizure disorder heart trouble diabetes
 physical handicap other (please specify) _____

Is your child taking any daily medicine: yes no If yes, please list: _____

Check Yes or No to indicate if you allow your child to receive the following medications while participating in FBC Events

- YES NO Acetaminophen (Tylenol ®) or Ibuprofen (Motrin ® or Advil ®) at an age or weight appropriate dose for discomfort, pain, or fever *** Parent/Guardian will be contacted if fever is 100° F or higher.
- YES NO Antacid liquid or Antacid tablets for indigestion/minor stomach discomforts and at an age appropriate dose
- YES NO Diphenhydramine (Benadryl®) for symptoms of allergic reactions, insect stings, or rashes at an appropriate dose
- YES NO Sore throat relief spray for sore throat
- YES NO Cough Drops for coughing
- YES NO Itch and rash relief cream/ointment for minor skin irritations
- YES NO Lubricating eye drops for eye irritations
- YES NO Oral pain relief gel for tooth/mouth discomfort
- YES NO Triple antibiotic ointment for minor skin abrasions/wounds

INSURANCE INFORMATION

PARENT/GUARDIAN: If you have hospitalization- medical insurance please attach a copy of the insurer's card to this form or be sure that the child has his/her own card so that we may provide it to hospital or emergency facility should treatment be needed and you are not with your child. If you do not have a card please provide the following information:

NAME OF INSURANCE CO.: _____ POLICY/GROUP NUMBER: _____

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MEDICAL TREATMENT CONSENT FORM

The following statement must be signed by the parent/guardian. This is needed because most medical facilities will not treat a minor without parental consent.

I, the undersigned parent or guardian of the minor named above, give my permission for the First Baptist Swainsboro staff or volunteers to seek emergency medical treatment for my child while in his care and we are not present. I agree to assume all financial responsibility, other than applicable insurance coverage, for such treatment and agree not to hold First Baptist Swainsboro or any of its staff or volunteers liable for payment of such medical treatment. This does not in any way relieve First Baptist Swainsboro or any of its staff or volunteers from responsibility for any negligence resulting in injury to my child.

_____ (signature of parent/guardian)

_____ (date)

Student Behavior Contract

Our ministry seeks to create an environment of fellowship, activities, and programs that will, while working alongside families, train and educate students toward maturity in Christ. A component of this environment

includes certain behavior and cooperation standards that the students are expected to follow.

Expectations/Consequences:

- Respect God, property, one another, staff, and all adult leaders.
- Comply with event schedules—participation with the group is expected.
- Acts of physical violence, weapons, fireworks, lighters, or explosives of *any* kind are not allowed.
- Use appropriate language.
- Modest and un-offensive clothing is expected.

Students who fail to comply with these expectations will receive the following consequences at the Student Pastor's discretion:

- **1st Offense: Verbal Warning**
- **2nd Offense: Loss of free time/Phone Call to the parents**
- **3rd Offense: Phone call to the parents and a month off from our Wednesday Night Programs. (After a month if things have not changed they will be asked not to come back)**

I, the student, have read the rules of conduct, the evaluation of my health, and permission to participate in youth group activities (listed below). I agree to abide by the stated personal limitations and code of conduct.

Student Signature _____

Date ___/___/____

Parent Signature _____

Date ___/___/____

Pick-up Information: Who may pick-up your Child on Wednesday Nights?

1.

2.

3.