KidZone Registration/Release

Great Exchange Covenant Church
2346 Walsh Ave.
Santa Clara, CA 95051
Phone: 408-988-0222
Fax: 408-988-0333
Email: KidZone@grx.org

Please fill out all information that is applicable:

We would like to be added to the registration system and receive future emails

We're visiting and would NOT like to be added to the registration system or receive future emails

PARENT/GUARDIAN INFORMATION (BLUE BOLD is REQUIRED)

First & Last Name	**Cell/Phone**	**Email Address**

Street Address, City, Zip	Home Phone

CHILD INFORMATION (BLUE BOLD is REQUIRED)

First & Last Name	**Birth Date**	**Grade**	Allergies/Special Needs/Other Concerns	*KidZone Class (Ops Use Only)*

EMERGENCY INFORMATION (BLUE BOLD is REQUIRED) (someone other than parents listed above)

First & Last Name	**Relationship to Child**	**Phone Number**

PERMISSION, AUTHORIZATION TO TREAT A MINOR, LIABILITY, ACCIDENTAL INJURY & PHOTO RELEASE

I, ____________ _____________ (parent's/guardian's first and last name) hereby grant permission for my child listed above to participate in KidZone services. I understand that children participating in KidZone will be under the supervision of and responsible in conduct to KidZone Leaders at all times. I understand that the name(s) listed for "Authorization for Drop Off and Pick Up" or any individual with possession of my child's Key Tag or Card has permission to check-in or check-out my child.

I/We hereby give permission for my/our child to attend KidZone. I/We give the group leaders permission to take any necessary action in the event of an emergency. I/We, the undersigned, parent(s)/guardian(s) of the child listed above, a minor, do hereby authorize KidZone at Great Exchange Covenant Church (GrX), as agent(s) for the undersigned to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered under the general or specific supervision of any physician and surgeon licensed under the provisions of the Medical Practices Act or the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

I/We, the parent(s)/guardian(s) of the child listed above, hereby acknowledge that my/our child and I/we freely and voluntarily have chosen to participate in KidZone conducted by GrX. I/We hereby agree to defend, protect, save and hold harmless GrX, participating private entities, and/or any cooperating or sponsoring public entities and their respective agents from any liability for accidental personal injury, accident, illness, death, or property damage which I/we or my/our child may suffer arising out of his/her/their participation in GrX programs.

I/We, the parent(s)/guardian(s) of the child listed above, realize that pictures may be taken at KidZone by KidZone staff for fun memories and/or future promotional purposes and hereby give permission for my/our child to be photographed.

_________________________________ _________________________________ ______________________

Parent/Guardian (print first & last name) **Signature** **Date**

Office Use Only:
- Entered Data ______ /_______ /________
- Other ______________