

Calvary Chapel Children's Ministry Family Registration Form

FOR OFFICE USE ONLY

FAMILY NAME: _____

ASSIGNED CM # _____

PARENT/GUARDIAN NAME(S): _____

ADDRESS: _____

HOME PHONE: _____ ALTERNATE PHONE: _____

EMERGENCY CONTACT IF YOU CAN NOT BE REACHED

NAME: _____ PHONE NUMBER: _____

**I GIVE CALVARY CHAPEL OF LEXINGTON PERMISSION TO SEEK MEDICAL CARE
FOR MY CHILD(REN) LISTED BELOW IN THE EVENT THAT I CAN NOT BE REACHED.**

SIGN: _____ DATE: _____

CHILD'S NAME: _____ AGE: _____

DATE OF BIRTH: _____ GRADE: _____

ALLERGIES/MEDICAL CONDITIONS: _____

CHILD'S NAME: _____ AGE: _____

DATE OF BIRTH: _____ GRADE: _____

ALLERGIES/MEDICAL CONDITIONS: _____

CHILD'S NAME: _____ AGE: _____

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