

Grace Chapel
Children's Ministry Registration

Name: _____ Date of Birth: ___/___/___
(Child's full name) Month/Day/Year

Address: _____
Street
_____ Home Phone: _____
City _____
_____ Cell Phone: _____
Zip Code _____

Parents : _____
Father Mother

Email: _____

Medical Alert: _____
Fill in medical information on backside of card

Medical Information

Name: _____

Food Related Allergies: _____

Epi Pen Alert: _____

(please state allergy that requires epi pen and where epi pen is located)

Other Allergies: (latex, activity induced asthma, pollen...)

Other Medical Information: (anything you feel we should be aware of)
