

# **MIDDLE SCHOOL MISSION**

## **Broad Street Ministry Summer 2017 Trip Registration Form**

### **Instructions:**

1. Complete the front and back of each page of the registration form and **PRINT CLEARLY**.
2. Please include a check (payable to Bryn Mawr Presbyterian) for the full payment with the registration form
3. Turn or mail in to BMPC (625 Montgomery Avenue, Bryn Mawr, PA 19010), attention Amy Bauer.

**Middle School Mission, Philadelphia, July 9 – 13<sup>th</sup>, 2017: \$299**  
Rising 6<sup>th</sup> – Rising 8<sup>th</sup> graders | Engage your faith in educational service experiences related to prevalent social justice issues.

\*Scholarship assistance based on need is available for all trips and events

### **CONTACT INFORMATION**

#### **PARENT/GUARDIAN CONTACT INFORMATION (PLEASE PRINT CLEARLY)**

Participant's Last Name \_\_\_\_\_ Participant's First Name \_\_\_\_\_  
Participant's Date of Birth (MM/DD/YYYY) \_\_\_\_\_ Current Grade in School \_\_\_\_\_  
Tee Shirt Size (Mission Trips & Camp Only) \_\_\_\_\_  
Parent(s)/Guardian Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ E-Mail \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

#### **EMERGENCY CONTACT INFORMATION**

Parent(s)/Guardian Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Contact Name \_\_\_\_\_ Relation \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Contact Name \_\_\_\_\_ Relation \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Forms are Available at: [www.bmpc.org/programs/for-youth-and-their-families](http://www.bmpc.org/programs/for-youth-and-their-families)

## AUTHORIZED PERSON FOR PICK UP

Contact Name \_\_\_\_\_ Relation \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Contact Name \_\_\_\_\_ Relation \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

## IMAGE/NAME PERMISSION & RELEASE

Bryn Mawr Presbyterian Church staff members may wish to photograph, videotape, or otherwise record the activities of the Program participants for the purpose of promoting the Program. We may also publish your participant's name, grade, and image on Church related publications.

I give permission for my child in the Program to be videotaped, photographed, and/or recorded, in connection with the Program. I give permission for Bryn Mawr Presbyterian Church to use said videotaped, photographed, and/or recorded materials in BMPC publications, websites, CDs, DVDs or other media, for publicity purposes or in any other non-commercial manner that it chooses.

I hereby waive and release any rights that I may have to said videotaped, photographed, and/or recorded materials.

Child's Name (please print) \_\_\_\_\_

Parent/Guardian Name (please print) \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## MEDICAL FORM

### INSURANCE INFORMATION

Name of Insurance Policy Holder \_\_\_\_\_

Carrier \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

### PHYSICIAN INFORMATION

Physician's Name/Practice \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Office Location \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

# MEDICAL CONDITIONS

**PLEASE CHECK ALL THAT APPLY**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> ADD                 | <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Mental Health Problems |
| <input type="checkbox"/> ADHD                | <input type="checkbox"/> Dizziness/Fainting/Blackouts                                      | <input type="checkbox"/> Motion Sickness        |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Eating Disorders  | <input type="checkbox"/> Orthopedic Problems    |
| <input type="checkbox"/> Cardiac Problems    | <input type="checkbox"/> Epilepsy  | <input type="checkbox"/> Stomach Problems       |
| <input type="checkbox"/> Chronic Bed Wetting | <input type="checkbox"/> (if applicable) Has your daughter had her first menstrual period? |   |

**ALLERGIES** (*Check*)  
(*Medication/Dosage*)

- Aspirin
- Food Allergies
- Insect Stings
- Latex
- Other Medication
- Other Medication
- Penicillin
- Sulfa
- Tetracycline

**REACTION** (*Describe*)

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**TREATMENT**

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***SPECIAL MEDICATION:*** *This information will be kept confidential. Please specify all medication(s) your child/student is currently taking, the dosage and how often it should be administered. Please note that we will not administer any medication during program hours unless we have written permission from you and your child/student’s physician. Please be sure to supply any medication necessary for your child. **All medications should be clearly labeled with name and instructions and placed in a sealed, clear plastic bag.***

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**PLEASE NOTE: We are unable to dispense any medication without documentation from your child’s doctor. This includes: aspirin, acetaminophen, ibuprofen, Benadryl, Epi-Pen.**

## **MEDICAL TREATMENT PERMISSION & RELEASE**

I desire my child to participate in the Bryn Mawr Presbyterian activity described herein (“the Program”). I understand that there are hazards and risks, as well as benefits, associated with my child’s participation in the Program. In consideration of the benefits of my child’s participation in the Program, I, on behalf of myself, my child, my or their heirs, executors, administrators, agents, assigns, and other personal representatives, irrevocably and unconditionally remise, release, settle, compromise, and forever discharge any and all manner of suits, actions, causes of action, damages and claims, known and unknown, that I or my child, have or may have against Bryn Mawr Presbyterian Church and/or its trustees, officers, employees, agents, assigns, contractors, or volunteers arising from or connected with my child’s participation in the Program, including the securing of medical treatment for my child during my child’s participation in the Program.

I give my permission to Bryn Mawr Presbyterian Church, its employees, agents, assigns, contractors, or volunteer supervisors to secure medical treatment for my child in the event that such treatment is needed during my child’s participation in the Program or related activities. I agree to assume financial responsibility for the cost of such treatment.

The laws of the Commonwealth of Pennsylvania shall apply to this Medical Treatment Permission & Release. If any of the provisions, terms, clauses, or waivers or releases of claims or rights contained herein are declared illegal, unenforceable, or ineffective in a legal or other forum or proceeding, such provisions, terms, clauses, or waivers and releases shall be deemed servable, and all other provisions, terms, clauses and waivers and releases of claims and rights contained herein shall remain valid and binding.

I sign this document with the intent to be legally bound by it. I am an adult, competent to sign this document. I am signing this document voluntarily. I have read it and I understand its contents.

Parent(s)/Guardian Name (*please print*) \_\_\_\_\_

Parent(s)/Guardian Name (*signature*) \_\_\_\_\_ Date \_\_\_\_\_