

REGISTRATION FORM – ST. PAUL’S CHILDREN’S MINISTRIES  
FOR ALL CHILDREN – AGES BIRTH THROUGH EIGHTH GRADE

Child’s Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
MM-DD-YYYY

Parent’s  
Names: \_\_\_\_\_

Home  
Address: \_\_\_\_\_  
STREET CITY STATE ZIP CODE

Primary Residence? YES or NO (circle one) If not, please provide additional information below:

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Home Phone Number: (\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_

Work Number Father: (\_\_\_\_) \_\_\_\_\_ Mother: (\_\_\_\_) \_\_\_\_\_

School (as of Sept 2006): \_\_\_\_\_ City: \_\_\_\_\_ Grade: \_\_\_\_\_

Has your child been in Church School before? YES or NO (circle one)

If YES, where and when? \_\_\_\_\_

Does your child have any special needs (allergies, restrictions, etc.)? YES or NO (circle one)

Please describe: \_\_\_\_\_

**MEDICAL TREATMENT**

*While we hope you will remain on the church campus during children’s programs, we want to be prepared for the unexpected; therefore, we ask you to provide the following information:*

**If I cannot be reached in an emergency, please contact:**

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

*Every effort will be made to reach me in an emergency. However, if I cannot be reached, I give my permission to the staff to secure the services of a licensed physician to provide the care necessary, including anesthesia, for my child’s well-being.*

Insurance carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent / Guardian

Please return the completed form to:  
St. Paul’s Episcopal Church  
ATTN: Church School Registration  
1924 Trinity Avenue  
Walnut Creek, CA 94596