JAM Registration Form APRIL 2024

PERSONAL CONTACT DETAILS			
Family Name			
Child/ren's name(s)	**1**	**Date of Birth**	**1**
	2		**2**
	3		**3**
	4		**4**
Address			
Phone no.		**Email**	
Parent/Caregiver's name		**Signature**	

PERMISSION TO PARTICIPATE	
I consent to my child/ren to take part in the approved activities for JAM	
Signed	**Date**

PERMISSION TO VIEW VIDEOS	
I consent for my child/ren to view (G) General rated DVDs. I understand that all material will be previewed prior to viewing.	
Signed	**Date**

PERMISSION TO BE TRANSPORTED BY LEADERS	
I give permission for my child/ren to be TRANSPORTED to/from venue by leaders in a private car or bus. I understand the church, its employees and volunteers are not liable for accident or injury to participants.	
Signed	**Date**

PERMISSION TO BE FILMED OR PHOTOGRAPHED
I give permission for my child/ren to be photographed or filmed. I understand that the image may displayed in church publications or website. I understand that the child/ren's name/s will not be published or linked with images.
Signed

CONFIDENTIAL MEDICAL REPORT						
The information below is requested to assist in case of illness or accident. This information will be confidential.						
Child	**Condition**	**Tick**	**Medication type**	**Self admin Y/N**	**Allergy Y/N**	**Specify**
Child (1) Name	**Heart**					
	Asthma					
	Diabetes					
	Other					
Child (2) Name	**Heart**					
	Asthma					
	Diabetes					
	Other					
Child (3) Name	**Heart**					
	Asthma					
	Diabetes					
	Other					
Child (4) Name	**Heart**					
	Asthma					
	Diabetes					
	Other					
Please list any physical or special needs:						

DECLARATION		
To the best of my knowledge, the information provided is correct. The GATEWAY BAPTIST CHURCH and COMMUNITY CENTRE, its Pastors and leaders of JAM will exercise adequate supervision but will not be held responsible for accident or injury. In the event of injury/ accident, and caregiver/parent is unavailable, I authorise medical assistance to be provided and agree to meet all expenses incurred. I allow appropriate medical information to be given to attending health care professional.		
Name	**Signature**	**Date**