

Vacation Bible School (VBS) Enrollment Form

暑期聖經學校(VBS)報名表

Student Information 學生資料		
First Name 名 :	Last Name 姓 :	
Date of Birth 出生日期 :	Gender 性別 : M (男) <input type="checkbox"/> F (女)	
Home Address 地址 :		
City 城市 :	State 州 :	Zip code 郵編 :

Parent/Guardian Information 家長/監護人資料		
First Name 名 :	Last Name 姓 :	
Relationship to Student 與學生關係 :	Phone Number 手機號碼: () -	
Email Address 電子郵件 :		

Emergency Contact 緊急聯絡人		
Name 姓名 1 :	Name 姓名 2 :	
Relationship to Student 與學生關係 :	Relationship to Student 與學生關係 :	
Phone Number 手機號碼: () -	Phone Number 手機號碼: () -	

Authorized Pick-Up Information 接送授權		
Names of adults authorized to pick up the child 以下人員經家長授權，可接送學生離開		
Name 姓名	Relationship to Student 與學生關係	Phone Number 手機號碼
1.		
2.		
3.		

Parent Consent and Participation Agreement

家長授權與參加同意書

Welcome to Vacation Bible School (VBS)! To ensure that every child enjoys a safe, caring, and meaningful experience while learning God's Word, building friendships, and participating in activities, please review the following information carefully and sign below.

歡迎您的孩子參加本次暑期聖經學校(VBS)！為了讓每位孩子都能在安全、關懷與喜樂的環境中學習神的話語、建立友誼並享受活動，請家長／監護人詳閱以下內容並簽名確認。

Security Recording and Activity Documentation

安全錄影與活動紀錄

For the safety and security of all participants, staff, and volunteers, photographs and/or video recordings may be taken during VBS activities and on church premises. Such recordings may be used for supervision, attendance verification, incident investigation, emergency response, and internal recordkeeping purposes.

為保障所有學員、工作人員及志工之安全，活動期間及教會場所內可能進行錄影、監視錄影及拍照。相關影像可用於安全管理、出席確認、事件調查、緊急應變及內部活動紀錄等用途。

Photo & Video Release for Publicity (Optional)

照片及影音公開使用授權（選填）

Photographs and/or videos of camp activities may be used in newsletters, websites, social media, brochures, presentations, and other promotional materials.

活動照片及／或影音資料可能用於電子報、網站、社群媒體、刊物、簡報及其他宣傳資料。

Yes, I grant permission 同意公開使用

No, I do not grant permission 不同意公開使用

Emergency Medical Authorization

緊急醫療授權

I understand that reasonable precautions will be taken to ensure participant safety. In the event of an illness, injury, or medical emergency, VBS staff will make reasonable efforts to contact a parent or guardian. If immediate medical attention is deemed necessary, I authorize VBS staff to contact 911 and obtain appropriate emergency medical assistance for my child.

本人了解教會將盡合理努力維護學員安全。如本人子女於活動期間發生受傷、生病或其他需要即時處理之緊急狀況，教會工作人員將盡力聯繫家長或監護人；如情況需要立即處理，本人授權主辦單位聯絡 911 或安排適當之緊急醫療協助。

Health Information Verification

健康資訊確認

I certify that all medical, allergy, medication, and emergency contact information provided is accurate and complete, and I will notify the VBS of any changes.

本人確認已如實提供孩子之健康狀況、過敏史、藥物使用及其他相關資訊，並同意於資訊變更時主動通知主辦單位。

**I have read, understood, and agree to the above information and authorize my child to participate in this VBS program.

**本人已閱讀、了解並同意上述內容，並授權本人子女參加本次暑期聖經學校（VBS）活動。

Parent/Guardian Name

家長／監護人姓名：

Parent/Guardian Signature

家長／監護人簽名：

Date

日期：

Medical Information

醫療資訊

Allergy 敏感	
<input type="checkbox"/> Yes 有	If yes, please specify 如有，請列明：
<input type="checkbox"/> No 無	

Medical Conditions (asthma, diabetes, seizures, etc.) 慢性疾病或特殊健康狀況（如氣喘、癲癇、糖尿病等）	
<input type="checkbox"/> Yes 有	If yes, please specify 如有，請列明：
<input type="checkbox"/> No 無	

Current Medications 目前服用藥物：	
<input type="checkbox"/> Yes 有	If yes, please specify 如有，請列明：
<input type="checkbox"/> No 無	

Parent/Guardian Name
家長／監護人姓名：

Parent/Guardian Signature
家長／監護人簽名：

Date
日期：



TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name, First Name, Middle Name, Sex, Date of Birth, Address, City/Borough, State, Zip Code, School/Center/Camp Name, District Number, Phone Numbers, Health insurance, Parent/Guardian Last Name, First Name, Email, Cell, Work

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history, Allergies, Attach MAF if in-school medications needed, Does the child/adolescent have a past or present medical history of the following?, Medications, Attach MAF if in-school medications needed

PHYSICAL EXAM, Date of Exam, General Appearance, Describe abnormalities, Blood Pressure

DEVELOPMENTAL, Validated Screening Tool Used, Screening Results, Describe Suspected Delay or Concern, Nutrition, Hearing, Vision, Acuity, Dental, Hemoglobin or Hematocrit

CIR Number, Physician Confirmed History of Varicella Infection, Please attach lab reports

IMMUNIZATIONS - DATES, DTP/DTaP, Tdap, Polio, Hep B, Hib, PCV, Influenza, HPV, MMR, Varicella, Mening ACWY, Hep A, Rotavirus, Mening B, Other, Positive IgG, Date, Hepatitis B, Measles, Mumps, Rubella, Varicella, Polio 1, Polio 2, Polio 3

ASSESSMENT, Well Child, Diagnoses/Problems, ICD-10 Code, RECOMMENDATIONS, Full physical activity, Restrictions, Follow-up Needed, Referral(s), Other

Health Care Practitioner Signature, Date Form Completed, DOHMH ONLY PRACTITIONER I.D., Health Care Practitioner Name and Degree, Practitioner License No. and State, TYPE OF EXAM, Facility Name, National Provider Identifier (NPI), Date Reviewed, I.D. NUMBER, Address, City, State, Zip, REVIEWER, Telephone, Fax, Email, FORM ID#