C3Naz Students 2021-2022
Youth Group Information Form

Student's FULL Name: _____

Preferred Nickname: _____

Grade Enrolled in for 2021-2022: _____ Name of School: _____

Student's DOB: _____ Gender: MALE / FEMALE

T-Shirt Size: _____

CONTACT INFORMATION

Student's Cell # _____ TEXTING? YES / NO

Mother's Name: _____ Email: _____

Address: _____ Zip: _____

Daytime Phone: _____ Nighttime Phone: _____

Father's Name: _____ Email: _____

Address: _____ Zip: _____

Day Time Phone: _____ Nighttime Phone: _____

INTERESTS

Do you plan an instrument? _____ What do you play? _____

Are you in any music/theatre groups? _____ What groups? _____

What sports or games do you like to play? _____

Are you in any clubs? _____ What clubs? _____

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PARENTAL PERMISSION FORM

Emergency Contact Information

If parents cannot be reached, please contact:

Name/relationship	work#	home#	cell#
Name/relationship	work#	home#	cell#

Parental Permission for Youth Activities

I,_____, give my child permission to attend Youth Activities sponsored by Cross Community Church of the Nazarene between July 1, 2021 and August 31, 2022. I understand that the NexGen Pastor or a trained volunteer will provide leadership during the activities. I agree to give emergency information to the adult in charge if it is different from the information submitted on this form.

Parent/Guardian Signature_____ Date_____

Publication Release

I authorize Cross Community Church of the Nazarene, Portage, Michigan to use pictures of my child for church related publications.

Parent/Guardian Signature_____ Date_____

Medical Consent

We, the undersigned parent(s) or guardian(s) of _____, a minor, acknowledge that this form is filled out to the best of our ability and do hereby authorize a youth ministry adult worker of Cross Community Church of the Nazarene as agent(s) for the undersigned, to consent to any examination, x-ray, anesthetic, medical or surgical diagnosis or treatment or hospital care which is rendered under the supervision of any physician, surgeon, or dentist whether diagnosis and treatment is in a hospital or office of said physician.

Parent/Guardian Signature_____ Date_____

Insurance Information

Family Physician_____ Phone_____
Address_____
Insurance Carrier_____
Group Number_____ Policy Number_____

Medical Information

Please put an "X" in the appropriate circle, specify where indicated:

- o Allergies- please specify type and reaction: _____
- o Other Health Concerns/Conditions:_____
- o Medications Taken Daily: _____