

**St. Justin the Martyr Family Ministry
Parents Night Out**

Date of Event: **05/25/2012**

Bring your children to the church for fellowship with their friends while you enjoy the night out. **Bring brown bag dinner or have your child fed.** Also bring a snack to share. Feel free to include pajamas, pillow, or bedtime friends. Adults will be at the church supervising. If you need to cancel, please call the church office at 880-7671.

Please complete the information below and return to the coordinator prior to leaving your child so that we can have accommodations prepared.

There will be a \$20.00 fine per family should you cancel on the day of the event or do not show, having signed up.

Registration Form

Participant Information

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Address _____ Phone _____

Primary Physician

Name _____ Phone _____

Address _____ City _____

State _____ Zip _____

Health Insurance Carrier

Name _____ Phone _____

Group # _____ Policy # _____

Allergies or Pre-existing conditions (if so, note which child) _____

Guardian Permission/Release

I am the parent or legal guardian of the participant(s) named above. I hereby release the Orthodox Church in America; the Diocese of the South; the Central Florida Deanery, St. Justin Orthodox Church, the sponsoring agent, their agents and employees, the event coordinator and all volunteers, from any liability for all personal injuries known or unknown that the youth named above may incur due to reasons unrelated but not limited to negligence by participating in activities conducted, sponsored, or associated with the event stated above. **I understand that if my child(ren) does(do) not attend the event, I will be assessed a \$20 fee to cover the cost of the pre-arranged helpers.**

In the event of an emergency I, or my spouse, may be reached at the following numbers: Home _____
Cell _____ Spouse's Cell _____

Also, in the event that I cannot be reached in the case of emergency, I authorize a physician, selected by the coordinator, to administer emergency treatment including medications, diagnostic tests, surgery, dental aid or other medical intervention deemed necessary by the physician.

I, the undersigned, have read this release and understand all its terms. I execute it voluntarily on behalf of myself and the participant(s) named above, and with full knowledge of the significance, to bind all persons.

Parent / Guardian Name (please print) _____

Signature _____ Date _____