Thank you for your interest in the Kingdom Kids Program! Our Pastor Darrell L. Fairer along with the entire Greater Faith Bible Tabernacle Community are excited to welcome you and your family to this life changing program!

Enclosed are the required registration forms. **This registration form must be completed prior to the start of the Kingdom Kids program.** Once form is completed you may mail or personally deliver it to:

Greater Faith Bible Tabernacle
391 Edison Ave.
Buffalo, NY 14215

We look forward to an exciting new journey with your child joining the **KINGDOM KIDS**!

STUDENT'S INFORMATION

First Name:_____ Last Name _____

Address: _____

City:_____ State: _____ Zip Code: _____

Home Phone: _____Cell Number: _____

Please circle one: Male or Female Date of Birth: _____ Age: _____

School: _____ Grade: _____

PARENT/GUARDIAN INFORMATION

Mothers Name: _____

Home Number: _____Cell Number: _____Work Number: _____

Fathers Name: _____

Home Number: _____ Cell Number: _____ Work Number: _____

EMERGENCY CONTACT

Name:_____ Relationship: _____

Home Number: _____ Cell Number: _____ Work Number: _____

Name:_____ Relationship: _____

Home Number: _____ Cell Number: _____ Work Number: _____

MEDICAL INFORMATION

Known Allergies: _____

Other known medical conditions: _____
In the event of an emergency or injury I give my permission to have, _____ treated by a medical physician at the nearest medical clinic or hospital. I also give my permission to deny my student to be treated at a medical facility if a staff person of the Kingdom Kids can treat him/her or deem it not to be necessary to be transported to the hospital.

MEDIA RELEASE

I approve pictures, video recording, quotes, etc. to be taken of my student at the Kingdom Kids program and to be used in any marketing efforts and all publications.

DISMISSAL

( ) My student is a walker, and will be dismissed to walk home at the end of the Kingdom Kids program.

( ) I will pick my student up DAILY from the program no later than 10 minutes after the scheduled dismissal time. I will enter the site and sign my student out each day. I understand that I must arrive within the scheduled pick up time or local enforcement authorities will be contacted.

The following are the ONLY adult persons over the age of 18 years of age that are authorized to pick up my student from the Kingdom Kids program:

*Name: _____ Relationship: _____

Home Number:_____Cell Number: _____ Work Number: _____

*Name: _____ Relationship: _____

Home Number:_____Cell Number: _____ Work Number: _____

*Name: _____ Relationship: _____

Home Number:_____Cell Number: _____ Work Number: _____

***This person must provide valid photo ID to the staff member on duty before the student will be released.**

In consideration of my student's participation in the Kingdom Kids program, I hereby release Greater Faith Bible Tabernacle, their employees, partners, and volunteers from any and all liability of injury or damage to my student while participating in the Kingdom Kids program.

Guardian Printed Name: _____

Guardian Signature: _____Date: _____

Every student needs a completed health form. *For use by program administration (or emergency medical personnel)*

SECTION I - BASIC CONTACT INFORMATION

Name: _____Date of Birth: _____ Gender: ☐M ☐ F
Family Physician Name: _____ Phone: _____
Dentist/Orthodontist Name: _____ Phone: _____

SECTION II - INSURANCE INFORMATION

Student is covered by family medical/hospital insurance? □Yes □No
If yes, indicate Insurance Carrier _____
Group # _____ Policy# _____
Policy Holder's Name _____ Relationship to participant _____

SECTION III - HEALTH HISTORY

Does the student have a history of or is prone to any of the following (Please check all that apply).

□ 1. Recent injury, illness or infectious disease
□ 2. Chronic or recurring illness
□ 3. Asthma
□ 4. Homesickness
□ 5.Frequent Ear infections
□ 6. Seizure Disorder or Convulsions
□ 7. Dizziness during or after exercise
□ 8.Chest pain during or after exercise
□ 9. Heart Defect or Disease
□ 10. Hypertension
□ 11. Bleeding/Clotting disorders
□ 12. Diabetes
□ 13. Mononucleosis (in last 12 months)
□ 14. Chicken Pox
□ 15. Measles
□ 16. German Measles
□ 17. Mumps
□ 18. Tuberculosis
□ 19. Hepatitis
□ 20. Joint problems (knees, ankles)
□ 21. Fractures
□ 22. Frequent headaches
□ 23.Head Injury
□ 24.Eating Disorder
□ 25. Diarrhea or Constipation
□26.Frequent Stomachaches
□27. Wears glasses or contacts
□28. Been Hospitalized
□29. Wears a Medic Alert ID

Please list the number and provide explanation for any checked items (where necessary):_____
_____
Date of Last Physical Exam: _____
Physical Activities to be Limited or Restricted while at Program: _____
_____

PLEASE NOTE: GREATER FAITH BIBLE TABERNACLE MUST BE NOTIFIED IF THIS STUDENT IS EXPOSED TO ANY COMMUNICABLE DISEASES DURING THE THREE (3) WEEKS PRIOR TO THE START OF PROGRAM ATTENDANCE.

SECTION IV - ALLERGIES

Does student have any allergies? □ Yes □ No *(If yes, check all that apply **and indicate type of reaction**)*

Hay Fever _____ _____
(type of reaction)

Poison Ivy/Oak _____
(type of reaction)

SECTION IV - ALLERGIES (CONT'D)

Bees/Insects _____
(type of reaction)

Food _____
(type of reaction)

Penicillin_____ Other allergies _____
(type of reaction) (type of reaction)

Child requires EPIPEN ☐**Yes** ☐ **No** ☐ **Stored on-site** ☐ **Carried by student**

Child requires INHALER ☐**Yes** ☐ **No** ☐ **Stored on-site** ☐ **Carried by student**

SECTION V - MEDICATIONS

MEDICATIONS ADMINISTERED BY STAFF? ☐Yes ☐No (If yes, fill our MEDICATION FORM printed below)

For the health and safety of the children, NY State Health Department guidelines are followed for the storage and administration of all medications brought on site. This completed form must be on file in order for your child to attend this program. ALL MEDICATIONS SHOULD ARRIVE THE WEEK BEFORE START OF PROGRAM OR ON THE STUDENT'S FIRST DAY. All medications will be stored in a locked storage facility.

MEDICATION MUST BE DELIVERED TO PROGRAM ADMINISTRATION BY PARENT/GUARDIAN

Prescribed medication must be kept in original container bearing the pharmacy label which shows the date filled, the prescribing practitioner, the name of the prescribed medication, directions for use, any cautionary statements contained in such prescription (or as required by law), and the number of tablets or capsules in the container.

ALL DOCTOR'S NOTE IS REQUIRED FOR ALL PRESCRIPTIONS

Provide complete name, dosage, and directions for each medication listed below. Be specific and include preferred time(s) of administration.

MEDICATION FORM must be completed. If not, medication CANNOT be administered by staff. (Please print)

Medication Name	Dosage	Time(s) Given

PHYSICIAN'S NAME_____PHONE_____

PHYSICIAN'S SIGNATURE_____

I give my permission for my child to self-administer his/her INHALER at this program. ☐**Yes** ☐**No** ☐**N/A**

I acknowledge that my child can self-administer his/her EPIPEN as prescribed by a physician. ☐**Yes** ☐**No** ☐**N/A**

PARENT'S SIGNATURE _____DATE _____

SECTION VI - ADDITIONAL INFORMATION

Are there any special or behavioral needs your student has that we need to be aware of? If yes, what are they?

_____

_____

_____

_____

Are there things that trigger negative behavior in your child? If so, what are they?

_____

_____

_____

_____

What are things that help your child to get calm if they become upset?

_____

_____

_____

_____

SECTION VII - AUTHORIZATION

My child has permission to engage in all prescribed program activities except as noted. The information provided on this form is accurate to the best of my knowledge. I have indicated any special health conditions, including required medication and activity limitations which should be known to the program administration and medical personnel. I am aware of and accept the risk inherent in the program activity. I give consent in advance for medical treatment at an appropriate facility in case of illness or injury.

Signature of Parent or Guardian

X_____Date_____