VBS Registration 2025

June 23-26, 5:30 – 7:30 pm

All Saints Catholic Church
3330 14th St. Lewiston, ID

For incoming Kindergarten thru 5th grade

Cost: $20 for one child, $30 for 2 children, $50 for 3 or more (includes dinner)

*Make checks payable to *All Saints Catholic Church*. Fee is due upon registration. *

*Registration is due to the parish office **June 5th** to guarantee a T-shirt. *

Name: _____ Grade this fall: _____ Shirt Size: _____
Allergies/ Medical conditions: _____
Be paired in group with: _____

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Allergies/ Medical conditions: _____
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*****Please complete medical release form on the back. *****

Parent/ Guardian Name: _____
Email Address: _____ Phone: _____
In case of emergency, please contact: _____ Phone: _____
Will someone other than parents be picking up your child? _____
Phone: _____ Relationship: _____

Note: Registration will be accepted day of. There will be no guarantee for a T-shirt, or the group they are put in. Simple dinners are provided to the children.
All classes are mixed ages. This allows us to group siblings or special friends together, or separate them as you wish. Please indicate your preference for each child.

For more information, please contact Kristin Hardin at hardinkristin23@gmail.com or Margie Booth at All Saints 208-743-1012.

Growing Up Catholic

Medical Release Form

Name of event: _____

I (we), the undersigned parent(s) or guardian(s) of _____ , a minor, do hereby authorize adult volunteers of _____ (name of church) as agent(s) for the undersigned, to consent to any medical or surgical care deemed advisable by any accredited physician or surgeon in an approved emergency clinic or hospital. I further release from any liability _____ (name of church), any of its ministries or leaders in the event of an accident en route, during and returning from the above mentioned event. This agreement does not apply to claims for intentional misconduct or gross negligence.

Date signed _____

Parent/Legal Guardian (print) _____

Parent/Legal Guardian (sign) _____

Address_____ City _____

Emergency Phone: Home (_____) _____ Work (_____) _____

Health Insurance Company _____

Policy or Group Number _____ Phone (_____) _____

If parent/legal guardian is not available in an emergency, contact

Name _____ Phone (_____) _____

Regarding allergies, please indicate severity.

Please list any allergies. Include medications, foods, etc. _____

_____

If your child has a food allergy, will you provide an alternate snack and or dinner? Yes ☐ No ☐

Does your child have any medical or special needs, including medications currently being used?

No ____ Yes ____ If yes, please explain. _____

Doctor's Name _____ Phone (_____) _____

Dentist's Name _____ Phone (_____) _____

Date of last tetanus shot _____ Birth date _____