



# First Baptist Church Buda VBS Registration Form

PreK-Completed 5<sup>th</sup> Grade

June 1-4, 2026 8:30 am – Noon

**Child must be 4 years old on or before  
September 1, 2025 to attend.**

Child's Full Name: \_\_\_\_\_

Shirt Size (Please circle): Youth- XS, S, M, L, XL or Adult- S

Parent/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_

Parent/Guardian Cell#: \_\_\_\_\_ Work#: \_\_\_\_\_ Home#: \_\_\_\_\_

E-mail: \_\_\_\_\_

## Child's Information:

Birth Date: \_\_\_\_\_ Last Grade Completed in School: \_\_\_\_\_

Medical information that we need to know. Please include any **food allergies**:

\_\_\_\_\_  
\_\_\_\_\_

## **Emergency Contacts** (other than those listed above):

Name & Relationship to Child: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name & Relationship to Child: \_\_\_\_\_ Phone #: \_\_\_\_\_

## **Dismissal Information** – Who may pick up your child at the end of each VBS day?

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Other Information** – What can you tell us about your child that will help us meet his/her needs? \_\_\_\_\_

Does your child attend church? If so, where? \_\_\_\_\_

May we have permission to photograph your child? Yes \_\_\_\_ No \_\_\_\_

## Medical Emergency Consent Form

Child's Name: \_\_\_\_\_

Please Print – First and Last Name

I, (Parent/Guardian's Name)

\_\_\_\_\_ understand that the above-named child may participate in physical activities such as those held in recreation time. I understand that with any physical activity, there is a risk of injury. I fully accept this risk and do not hold any legal liability to: First Baptist Church Buda and/ or any persons involved in conducting Vacation Bible School at First Baptist Church Buda.

In the event of an emergency that requires medical treatment for the above-named child. I understand that every effort will be made to contact me or my emergency contact. However, if I cannot be reached, I give my permission to a VBS director/leader to secure the services of a licensed physician or qualified medical emergency professional to provide the necessary care for my child. I assume full responsibility for all costs connected to any accident or treatment of my child.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Parent/Guardian