



**SAINT AMBROSE CATHOLIC COMMUNITY  
VACATION BIBLE SCHOOL  
June 12–16, 9 am - 12 pm  
Registration Deadline: June 5, 2023**

All children ages 3\* (as of January 1, 2023) through 5th grade are invited to join us! We **cannot** take registrations after June 5.  
**\*Preschool-aged children must be potty-trained and able to separate.**

Parent/Guardian Name(s) \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
 Best Phone # \_\_\_\_\_ Alternate Phone # \_\_\_\_\_  
 Name of person(s) picking up child(ren) \_\_\_\_\_  
 Email address \_\_\_\_\_

- I do **NOT** want my child(ren) in a video/photo.
- I understand that VBS cannot be offered without community support, and agree to volunteer as best as I am able to help ensure the continued success of the VBS program at Saint Ambrose Catholic Church. \_\_\_\_\_ (Initial)

Child's Name	Birth Date	Age	M/F	Current Grade	Shirt Size*

*\*Shirt sizes come in child small (6-8); child medium (10-12); child large (14-16); and adult small (34-36)*

<b>REGISTRATION FEES</b> <i>(All fees are non-refundable)</i>	COST: \$35 per child X _____ (# of children) = TOTAL COST:	
	Music CD: \$7.50 per CD X _____ (# of CD's you are ordering) = TOTAL COST:	
	<b>TOTAL AMOUNT DUE:</b>	

**LIABILITY WAIVER AND MEDICAL RELEASE**

I, \_\_\_\_\_ grant permission for \_\_\_\_\_ to participate in the above named activity and I warrant that my child(ren) is in good health. In consideration of my child(ren)'s participation, I agree to indemnify Saint Ambrose Catholic Community and the Archdiocese of St. Paul and Minneapolis from any claim or lawsuits brought against Saint Ambrose Catholic Community and the Archdiocese of St. Paul and Minneapolis by myself, child(ren), or others, that arises out of any behavior by my child(ren) at the event/activity described above. I also agree to pay reasonable attorney's fees or expenses incurred by Saint Ambrose Catholic Church and the Archdiocese in defense of such a claim/lawsuit.

**EMERGENCY MEDICAL TREATMENT:** In the event of an emergency, I give permission to transport my child(ren) to a hospital for emergency treatment. I wish to be advised prior to any further treatment by a doctor or hospital. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

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

**Food Allergies, special needs or concerns?** (Please indicate which child): \_\_\_\_\_

Doctor Name \_\_\_\_\_ Phone # \_\_\_\_\_

As a parent/guardian, I agree to all of the above stated considerations and conditions.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

For office use only	
Check #/Cash:	_____
Total Pd:	_____
Initial:	_____