

# VBS 2026

## CHILD REGISTRATION FORM

### VBS LOCATION:

Blessed Sacrament Church  
3020 Reeves Rd. NE, Warren, OH

### VBS DATES:

Mon-Fri June 8th-12<sup>th</sup>

9:30 am-12:30 pm

Space is limited - Registration Due by May 24<sup>th</sup> 2026

\*Friday Closing Celebration

12 pm Program for Parents and Lunch to follow

**AGE:** *Cathletics* is for children ages 5 through 11. Child must be 5 years old by June 8<sup>th</sup>, 2026

**COST:** \$10.00/child with family max \$30.00

Checks Payable to "St. Teresa of Calcutta".

Payment can also be submitted online at [www.warrencatholic.org/bsp/](http://www.warrencatholic.org/bsp/).

You may also register online at [www.warrencatholic.org/bsp/](http://www.warrencatholic.org/bsp/)

### VBS Medical Release / Registration Form

Child's Name (First, Middle, Last) \_\_\_\_\_

Parent/Family/Guardian Name \_\_\_\_\_

Address \_\_\_\_\_

Parent Primary Email Address \_\_\_\_\_

Phone Numbers Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Date of birth \_\_\_\_\_ Age as of 6/8/2026 \_\_\_\_\_ Last school grade completed \_\_\_\_\_

Parish or Church \_\_\_\_\_

Special Needs/Allergies/Medical Information/Other \_\_\_\_\_

#### Emergency Contacts

Name \_\_\_\_\_ Phone \_\_\_\_\_

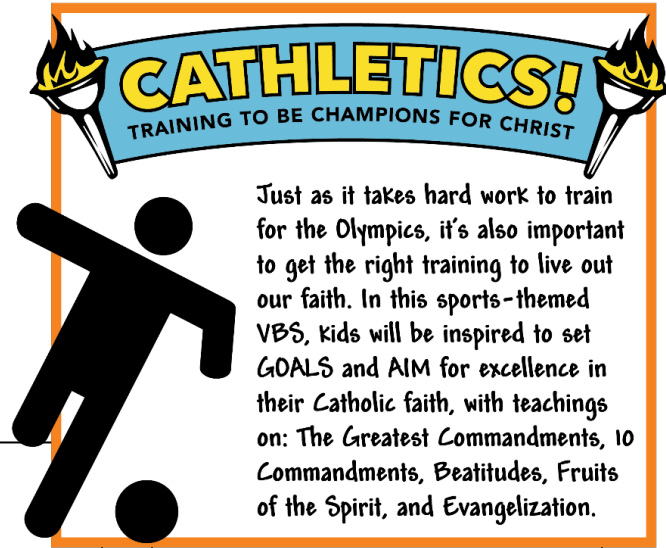
Name \_\_\_\_\_ Phone \_\_\_\_\_

Name(s) of person(s) who may pick up this child from VBS \_\_\_\_\_

\_\_\_\_\_

Today's Date \_\_\_\_\_

Name of Participant \_\_\_\_\_



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**Part 1: To Grant Consent**

I hereby give consent for the following medical care providers and local hospital to be called:

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Preferred Hospital (circle one)

Trumbull, **330-841-9011**, Akron Children's Urgent Care, **330 856-9699** St. Joseph **330-841-4000**

Insurance (if applicable): \_\_\_\_\_

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any reasonably accessible hospital.

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a doctor should be alerted:

ALLERGIES / MEDICAL CONDITIONS/ EDUCATIONAL SITUATIONS:

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

My child has an aide at school Yes No Please explain \_\_\_\_\_

\_\_\_\_\_

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

Relationship to child \_\_\_\_\_

**Part 2: Refusal to Consent**

I do **NOT** give my consent for the emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the Church authorities to take the following action:

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

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

Relationship to Student \_\_\_\_\_

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**Photo/Social Media Release:** The Parish Visitors of Mary Immaculate, the Catholic Community of Trumbull North, St. Teresa of Calcutta Parish, and Saint Pope John XXIII Parish, have my permission to use my child's photograph publicly in VBS materials. I understand the images may be used in print publications, online publications, presentations, websites, and social media. I also understand that no royalty, fee, or other compensation shall become payable to me by reason of such use.

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