

Participant's Name _____ D.O.B. _____

Program Name: _____

School Grade _____ M / F (Circle one)

Program Registration Form

Parent's Name _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone # _____

Cell Phone # (mom) _____ (dad) _____

Work # (mom) _____ (dad) _____

Email Address _____

Allergies? _____

Any Medications? _____

Need for any special accommodations? _____

Payment Type: cash _____ check #/date _____

SEE & TELL Fees are \$25 a child \$50 family Maximum

By Mail: Cross of Glory Lutheran Church Phone: 708-301-6998

14719 W. 163rd Street

Homer Glen, IL 60491

Fax: 708-301-7126

I release Cross of Glory and Staff or Volunteers from the responsibility of any injury incurred to my child while participating in any church activity/program and any theft or damage of personally owned property. By signing below I give my permission for the director to secure proper treatment in an emergency and for the use of photographs of my child in church publicity.

X _____
Mandatory signature of parent or legal guardian.