



Children's Ministries Visitor Check-In

Infants through 5th Grade

PRINT AND PRESS FIRMLY ON A HARD SURFACE.

Parent's Names _____

Your Name (If not the Parent) _____ Relationship to Child _____

Child's Address _____

City _____ State _____ Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____

Where will you be? _____

Child's Full Name	Date of Birth	Age	Grade	Sex	Allergies/Medical Condition	Tag#	Sign-Out

Turn in one page of this form at each child's class room.

Thank you for coming today.

Parents or a responsible party are required to remain on the premises while your children are here. If in the event an emergency arises and you are not available, your signature below will give us permission to authorize medical treatment.

Parent's signature _____