Fall 2024 Program Dates
Sept. 11,18,25
Oct. 2,9,16, 23, 30
Nov. 6,13,20
(no session Nov. 27)
Dec. 4,11,18

Wednesdays 3:30-5:15 pm
No session if school is cancelled

Fall 2024 Registration Form

Child's Name: _____Grade in 2024 school year: _____ Birthday _____

Child's Name: _____Grade in 2024 school year: _____ _____

Child's Name: _____Grade in 2024 school year: _____ _____

Child's Name: _____Grade in 2024 school year: _____ _____

Parent/Guardian contact information: Name(s): _____

Address: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____ _____ _____
Any special information we need to know about your child/children (allergies,extra support needed):

Treasure Seekers will end at 5:15pm. The following people have permission to pick up my children besides myself: (Please provide name & contact info.)

_____

In case of inclement weather, I give permission for my child to be driven from Lakeview to Solon UMC by a church volunteer (background checks are completed for ALL volunteers)

_____ Date_____

I give permission for my child/children to be photographed or videotaped during the program:
Yes (signature)_____ Date _____ No_____

$20 fee for one child/$35 for two children in one family/$45 max for one family/scholarships available
Make checks out to: Solon UMC, and mail this form to: Solon UMC, 122 N West St., Solon, IA 52333

Thank you! Dee Swartzendruber deeswartz@soloniaumc.org or cell (319) 624-2288

Solon United Methodist Church
Solon, Iowa

SAFE SANCTUARIES FOR YOUTH

Medical Information and Treatment Release Form
Form H

Name of child/youth: _____

Age/Birth Date: _____

Name of Parent/Guardian: _____

Emergency Contact Information: _____

_____

Previous Illness or Injury that may affect child's participation: _____

_____

Current Medications that may affect child's participation: _____

_____

Allergies: _____

_____

The undersigned parent(s)/guardian authorized the Solon United Methodist Church to secure medical/dental treatment for _____ in the event of any illness or accident for which
Name of child/youth
responsible adults of first aid personnel feel professional medical attention is required. I/We hereby give permission to the administration of any and all necessary medical/dental treatment by a licensed physician or dentist in his/her office or at a hospital.

Last date of tetanus booster: _____

Family Doctor: _____

Contact Information: _____

Family Dentist: _____

Contact Information: _____

Hospital Preference: _____

_____ _____

Parent(s)/Guardian Signature ***Date***

If registering more than one child, please copy this side and fill out one Medical Information form for each child