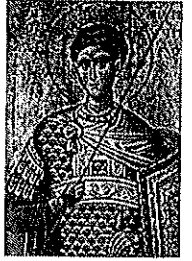




ST. DEMETRIOS GREEK ORTHODOX CHURCH

ΕΛΛΗΝΙΚΗ ΟΡΘΟΔΟΞΟΣ ΕΚΚΛΗΣΙΑ ΑΓΙΟΥ ΔΗΜΗΤΡΙΟΥ

Rev. Fr. George Kouzelis, Presiding Priest
Ιερατικός Προϊστάμενος π. Γεώργιος Κουζέλης



G.O.Y.A Registration Form

Name: _____

Address: _____ City: _____ State: _____

Birth Date: _____ Present Age: _____ Grade: _____

School: _____ City: _____

Interests and/or Talents (Check as many as apply):

- | | | | | |
|--|---|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Choir | <input type="checkbox"/> Oratory | <input type="checkbox"/> Sculpture | <input type="checkbox"/> Basketball | <input type="checkbox"/> Theater/Play |
| <input type="checkbox"/> Bicycling | <input type="checkbox"/> Photography | <input type="checkbox"/> Art | <input type="checkbox"/> Volleyball | <input type="checkbox"/> Literature |
| <input type="checkbox"/> Running/Track | <input type="checkbox"/> Instrument Soloist | <input type="checkbox"/> Greek Dance | <input type="checkbox"/> Field Sports | |
| <input type="checkbox"/> Monologue | <input type="checkbox"/> Crafts | <input type="checkbox"/> Voice Soloist | <input type="checkbox"/> Poetry | |
| <input type="checkbox"/> Dance | <input type="checkbox"/> Bowling | <input type="checkbox"/> Other: | | |

Emergency contacts:

Father's/Guardian's Name _____ Business Phone _____

Mother's/Guardian's Name _____ Business Phone _____

Health/Medical: Do you have any physical ailments, allergies, or restrictions? Do you take any medication or are you allergic to any medication? (Yes) (No)

If yes, please explain on opposite side (This information will be kept confidential).

Signature of Applicant _____ Date _____

I hereby give permission for my son/daughter to participate in any or all Local Jr. G.O.Y.A. Events, activities and/or Diocese of New Jersey State Youth sponsored events. I also give Permission for him/her to ride on the Bus or Van while attending these events, or in a private automobile with adult advisors/chaperons.

Signature of Parent/Guardian _____ Date _____

Photograph & Video Release Form

I hereby grant permission to the rights of my image, likeness and sound of my voice as recorded on audio or video tape without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Photographic, audio or video recordings may be used for the following purposes:

- conference presentations
- educational presentations or courses
- informational presentations
- on-line educational courses
- educational videos

By signing this release I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet or in the public educational setting.

I will be consulted about the use of the photographs or video recording for any purpose other than those listed above.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

This release applies to photographic, audio or video recordings collected as part of the sessions listed on this document only.

By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Full Name _____

Street Address/P.O. Box _____

City _____

Prov/Postal Code/Zip Code _____

Phone _____ Fax _____

Email Address _____

Signature _____ Date _____

If this release is obtained from a presenter under the age of 19, then the signature of that presenter's parent or legal guardian is also required.

Parent's Signature _____ Date _____

GOYA HEALTH PERMISSION FORM

GOYAN'S NAME _____

DATE OF BIRTH _____ PHONE # _____

ADDRESS _____

MOTHER'S NAME _____ EMPLOYMENT _____ cell # _____

FATHER'S NAME _____ EMPLOYMENT _____ cell # _____

FAMILY DOCTOR'S NAME _____ TEL # _____

HOSPITAL OF CHOICE _____

DENTIST'S NAME _____ TEL # _____

MEDICAL PROBLEMS _____

MEDICATIONS ON A REGULAR BASIS _____

KNOWN ALLERGIES _____ REACTION _____ TREATMENT _____

Names and telephone numbers of two persons to contact if your child is ill or injured.

In the event that the parent or guardian cannot be contacted, these persons and accompanying advisors might have to make a medical decision.

Name _____ Telephone _____

Name _____ Telephone _____

EMERGENCY MEDICAL TREATMENT

To the Parish Priest and Advisors: In the event that I am unable to be reached and my child needs EMERGENCY MEDICAL TREATMENT during any time he/she is a member of the G.O.Y.A., you have my permission, and I hereby designate you my agent, to act in my son's/daughter's best interest in obtaining necessary transportation and medical care until I can be contacted. I hereby release you from any claim arising out of the doctor's actions, and I assume and agree to pay for any professional medical services incurred.

Date _____ Parent/Guardian Signature _____

Permission for emergency medical treatment will be effective throughout the member's enrollment. If there is any change of information, please telephone the parish priest or Advisors.

YOUR INSURANCE COMPANY _____

GROUP IDENTIFICATION #: _____

MEMBER # _____

TELEPHONE # _____

RETURN WITH REGISTRATION FORMS

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MEDICAL FORMS**