Bible Quiz Nationals Quizzer Registration Form

This form is due, with $100 registration, by January 6th, 2024

Name _____

Quizzer Email (please write legibly!)

_____

Years quizzing at Nationals (include this year) _____ Graduation year_____

Parent Name _____

Parent Email (please write legibly!)

_____

Quizzer Phone _____ **Parent Phone** _____

I memorized: _____ 50-249 verses OR _____ 250 or more verses

Signature of coach that the quizzer has quoted *at least 50 verses* in one sitting:

_____

My chapter coverage by the end of the regular season will be best described as (indicate which one): _____ All the material **OR** Chapters as marked below:

Galatians	___1	___2	___3	___4	___5	___6
Ephesians	___1	___2	___3	___4	___5	___6
Philippians	___1	___2	___3	___4		
Colossians	___1	___2	___3	___4		
1 Thess.	___1	___2	___3	___4	___5	
2 Thess.	___1	___2	___3			
1 Timothy	___1	___2	___3	___4	___5	___6
2 Timothy	___1	___2	___3	___4		
Titus	___1	___2	___3			
Philemon	___1					

Quizzers should expect to be at all the tournaments (Iowa, Regionals and Nationals) and at least 3 scheduled practices. If not, please indicate which ones you will miss:

_____

_____

_____

_____

_____

Continue to back →

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Medical Release Form

TFC Function: 2024 Iowa Invitational, IA
TFC Function: 2024 Northern Regionals, Valley Baptist Church, MN
TFC Function: 2024 BQF Nationals, Wisconsin Dells, WI

Participant's name (Please Print) _____

Date of Birth_____ Age (at Nat'l)_____ Please circle one: Male Female

Address_____ City_____ State_____
Zip_____ Home Phone:_____

Mother's Name_____ Father's Name_____

Cell #_____ Cell #_____

If parents or legal guardian can not be reached in an emergency, Please contact:

Name_____ Phone_____

Name_____ Phone_____

In case of sickness or accident please complete the following as a precaution:

Your Hospital Insurance Company_____

Policy #_____ Group #_____

Does the participant have any allergies to medicines, food, or bee stings, etc?

_____

Does the participant have any medical conditions such as diabetes, asthma, heart problems, depression, ADD, ADHD, or any physical exercise limitations? (If yes, please explain)

_____

Name of medications that your child is taking. Please state the reason for taking it.

_____

Name_____ has my permission to take the following over the counter medicines for the following reasons:

		YES	NO
1.	Tylenol or Ibuprofen for headaches, pain, or fever-	☐	☐
2.	Benadryl, Calamine, or Caladryl lotions for insect bite/skin irritation-	☐	☐
3.	Antacids (Tums or Pepto Bismal) for upset stomach-	☐	☐
4.	Antibiotic cream such as Bacitracin for cuts and scrapes-	☐	☐

I hereby give my permission to medical personnel with proper credentials to give emergency medical treatment and care to the above named program participant.

_____ **Date**_____

(Must be signed by parent or legal guardian)