

# Bible Quiz Nationals Quizzer Registration Form

*This form is due, with \$100 registration, by January 3rd, 2026*

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:

1 Corinthians	___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10 ___11 ___12 ___13 ___14 ___15 ___16	
2 Corinthians	___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10 ___11 ___12 ___13	
1 John	___1 ___2 ___3 ___4 ___5	
2 John ___1	3 John ___1	Jude ___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:

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# Medical Release Form

This covers all Teens For Christ functions from January 1, 2026 to December 31, 2026.

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

**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)**