

AWANA September 4, 2018 – June 2019
COMMUNITY BIBLE CHURCH

CUBBIES (PRE-K) **(BLUE)**

ALLERGIES: FOOD __ MEDS __ OTHER __

GENERAL PERMISSION SLIP & EMERGENCY INFORMATION

<i>FOR REGISTRAR'S USE:</i>	CBC _____
Date: _____	AW _____
Cash/Check#: _____	
Amount: \$ _____	
FAMILY (#): _____	DUES PAID _____
BOOK(S) PAID For <u>THIS</u> Clubber: _____	
UNIFORM PAID For <u>THIS</u> Clubber: _____	
OTHER PAID For <u>THIS</u> Clubber: _____	

Child's Name: _____

PLEASE PRINT CLEARLY.

Date of Birth: _____ / _____ / _____ Male __ Female __

Home Church: _____

Uniform Size: _____

PRE-K:

Starting Kindergarten 09/2019 __ 09/2020 __ 09/2021 __

Address: _____

City: _____ Zip: _____ Home Phone: _____

PLEASE PRINT CLEARLY.

Previously enrolled in AWANA __ Last Book Completed: _____

FATHER (PRINTED): _____ **CELL PHONE:** _____

MOTHER (PRINTED): _____ **CELL PHONE:** _____

OR LEGAL GUARDIAN (PRINTED): _____ **CELL PHONE:** _____

E-mail Address(es): _____

PLEASE PRINT CLEARLY.

Where can you (Parent or Guardian) be reached during club time? _____

EMERGENCY CONTACT: Name: _____ **Phone:** _____

Doctor: _____ **Phone:** _____

Allergies or medications being taken: _____

General Permission and Authorization to Consent to Treatment of Minor

I, the undersigned, Parent or Legal Guardian, do hereby grant permission for the child named above, to attend all the Community Bible Church AWANA Club's organized outings during this club year. Should medical care be needed, I also authorize any licensed emergency personnel, doctor, paramedic, or hospital to perform any x-ray, examination, anesthetic, medical, or surgical diagnosis or treatment and care which is deemed advisable by said emergency personnel, doctor, paramedic, or hospital regardless of where such diagnosis or treatment is rendered. It is understood that this authorization is given in advance of any specific need for diagnosis, treatment, or hospital care and intended to provide authority and power on the part of any Awana leader or personnel to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned emergency personnel, doctor, paramedic, or hospital in his/her best judgment may deem advisable. This authorization is made under CA. Family Code Sec. 6910.

Signature of Father, Mother, or Legal Guardian: _____

(Please circle one.)

SIGNATURE

DATE

Printed Name of Person Signing _____

Version 07/27/2018

Registered By: _____