

Family Name: _____

AWANA CLUB APPLICATION AND MEDICAL RELEASE FORM

CLUBBER INFORMATION

Clubbers Name	DOB	Age	Grade	Club

PARENTS' NAME: _____

EMAIL ADDRESS: _____

HOME PHONE: _____ CELL: _____ WORK: _____

ADDRESS: _____

CITY, ZIP: _____

CHURCH YOU ATTEND ON SUNDAYS: _____

EMERGENCY INFORMATION

Persons to contact if parents can not be reached:

Name: _____ Relationship: _____ Phone: _____

TriCare: Yes ___ No ___ Physician's Name (if not insured by TriCare) _____

Physician's Phone: _____ Special instructions or medical conditions such as diabetes, allergies, etc.: _____

AUTHORITY TO CONSENT TO TREATMENT OF A MINOR(S)

(Parent/Guardian Name: Herein "Parent")

Koza Baptist Church
(Herein "Organization")

(Child's Name: Herein "Minor(s)")

AWANA Commander or Director
(Herein "Agent")

The above named parent or the minor(s) has entrusted the minor(s) into the care of the agent, an adult, and a duly authorized representative of the organization, while the minor(s) participates in the activities sponsored by the organization, and for the welfare of the minor.

The parent does hereby authorize the agent, as agent for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to rendered under the general or special supervision or, any physician and/or surgeon licensed under the laws of the country or county in which the medical care is being sought and on the medical staff of any hospital; or to consent to treatment to be rendered to the minor(s) by any dentist licensed under the laws of the United States and/or Okinawa, Japan in which dental care is being sought.

It is understood that this authorization is given in advance of any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care being required but is given to provide authority and power to the agent to authorize diagnosis, treatment, or hospital care which the aforementioned surgeon, physician, and/or dentist, in the exercise of his/her best judgment, may deem advisable.

The parent hereby authorizes any hospital which has provided treatment to the minor(s) to surrender physical custody of the minor(s) to the agent upon completion of the treatment.

The parent hereby agrees to fully pay all costs of medical and/or dental care incurred for the minor(s) by the agent, or the organization, under this authorization.

These authorizations shall remain effective August 26, 2009 until June 2, 2010, unless sooner revoked in writing delivered to said agent.

Parent/Guardian Signature

Date