

 Calvary Chapel San Diego 1771 E. Palomar St. ♦ San Diego CA 91913 Phone: 619.421.1100 ♦ Fax: 619.591.2262	
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Permission & Medical Release Information 2010-2011

Complete one form for each clubber

(Incomplete forms do not guarantee membership.)

Clubber's last name	First name	Date of birth	Grade	Club
Complete home address		Zip	Home telephone	
Father/Step father name		Work telephone	Cell phone	
Mother/Step mother name		Work telephone	Cell phone	

IN CASE I CAN NOT BE CONTACTED, PLEASE NOTIFY:

Name	Telephone	Relationship
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As the parent/guardian of my child/ward, I hereby permit him/her to attend and participate in all AWANA games, hiking, climbing, projects, and other related activities. I am aware that these activities may involve some hazard. I have considered these risks and I still wish my child/ward to participate. In consideration of my child/ward participating in these activities, I hereby release Calvary Chapel San Diego, its staff, sponsors or volunteers of any liability, which might result due to injury or illness of the my child/ward during the 2010-2011 club year. I understand that reasonable precautions will be taken to safeguard my child/ward.

I do hereby authorized the adult sponsor of this AWANA program bearing this authorization, into whose care the above mentioned minor child/ward has been entrusted, to obtain proper medical or dental care should my child/ward be injured or become ill during the aforementioned activities and I cannot be reached (excluding life threatening situations where contact will be made as soon with proper medical authorities). The medical/dental care is to include, but not limited to, an x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which the aforementioned physician or dentist in the exercise of his best judgment may deem advisable. This authorization shall include transportation to their chosen physician, dentist, medical center, and/or hospital to secure proper treatment.

In the event of injury or illness to my child/ward, I agree that I/we and my health care insurer shall be financially responsible for any medical treatment required by my child/ward as a result of any injury or illness suffered during his/her participation in any AWANA program activities. The insurance information noted below is my primary carrier.

Medical Insurance & Information to assist physician(s) in case of an emergency

Insurance Company: _____	Medication(s): _____
Insurance Policy No: _____	Allergies - Food: _____
Policy Holder's Name: _____	Allergies - Medication: _____
Pediatrician/Physician or medical facility: _____	Allergies - Other: _____
Physician Phone: _____	Other concerns/limitations: _____

Signature: _____ Relationship: _____

Date Signed _____