HSF AWANA Registration and Medical Release Form 2019-2020

Last Name: _____ Phone #: _____

Mailing Address: _____ Email: _____

City: _____ State: _____ Zip: _____

Names of Child(ren):	Age/Grade:	Medicine & Food Allergies (please write N/A if none):

Emergency Contact Information:

Father/Guardian: _____ Hm Phone: _____ Cell: _____

Mother/Guardian: _____ Hm Phone: _____ Cell: _____

If unable to contact above Emergency Contact, call:

Name: _____ Phone #: _____ Relationship to child(ren): _____

Medical Information and Releases:

Insurance Company: _____ Policy/Group #: _____

Doctor's Name: _____ Phone #: _____

Address: _____ City, State, Zip: _____

I hereby grant____ do not grant____ (check one) permission for HSF to use pictures of my child(ren) on their website for information and promotonial purposes. Initials_____

Medical Release: I hereby give my permission to the physician or dentist selected by Impact Bible Ministries to hospitalize, to secure proper treatment, and/or order an injection, anesthesia, or surgery for my child(ren) as deemed necessary, after every attempt to contact the parent, guardian, and/or other emergency contact has failed. I further agree that I am fully responsible to pay all charges and expenses relating to such care and treatment. My signature below serves to indicate my willingness for my Health Insurance Company to be billed for any and all medical fees and services should they be needed. I agree that I will pay all charges and expenses not covered by my insurance. My signature below also serves as a medical release for the above mentioned child(ren).

Parent/Guardian Signature: _____ **Date:** _____

Received AWANA Family Handbook: _____

Financial Record:

Date:	Payment:	Balance:	Initials: