

## AWANA Registration

### Children's Information

<p>Child 1 Name _____</p> <p>Birth Date _____ Gender (M or F) _____</p> <p>Grade _____</p> <p>Phone &amp; Address (if different from parent): _____</p> <p>Allergies: _____</p> <p>Special Accommodations: _____</p>	<p>Child 2 Name _____</p> <p>Birth Date _____ Gender (M or F) _____</p> <p>Grade _____</p> <p>Phone &amp; Address (if different from parent): _____</p> <p>Allergies: _____</p> <p>Special Accommodations: _____</p>
<p>Child 3 Name _____</p> <p>Birth Date _____ Gender (M or F) _____</p> <p>Grade _____</p> <p>Phone &amp; Address (if different from parent): _____</p> <p>Allergies: _____</p> <p>Special Accommodations: _____</p>	<p>Child 4 Name _____</p> <p>Birth Date _____ Gender (M or F) _____</p> <p>Grade _____</p> <p>Phone &amp; Address (if different from parent): _____</p> <p>Allergies: _____</p> <p>Special Accommodations: _____</p>

### Parent/Guardian Information

Parent(s)/Guardian Names (first & last) \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail Address \_\_\_\_\_ Primary Phone # \_\_\_\_\_

Dad - Cell Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Mom - Cell Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Emergency Contact Name (other than yourself) \_\_\_\_\_ Phone # \_\_\_\_\_

*form continues on the back*

## Medical, Liability, & Photo Release

In case of accident or serious illness, I request the Hope Lutheran Brethren Church (Hope LBC) staff to contact me. If the staff is unable to reach me, I hereby authorize them to call the physician below and if they are not available, make whatever arrangements seem necessary. If needed, we would like our child/children named above sent to \_\_\_\_\_ hospital. I hereby understand that Hope LBC does not provide any form of health or accident insurance should any injury occur.

I also give permission for the administration of Tylenol and/or Advil (Ibuprofen) to my child according to the manufacturer's instructions for the following reason(s) \_\_\_\_\_  
(e.g., headache, fever).

I further agree that I will not obligate Hope LBC or staff, whether paid or volunteer, to pay any medical expenses related to such an injury. This form releases Hope LBC and its staff, whether paid and volunteer, from any liability.

By my signature below and by having my child attend this Hope LBC event, I am giving my permission for photographs and videos to be taken and to be used or reproduced by Hope LBC for promotional and educational purposes including brochures, publications, illustrations, and our website. I understand that no names will be used along with pictures without further permissions. It is understood that my child/children will obey all regulations and follow instructions.

Physician's Name (or clinic) \_\_\_\_\_ Phone Number \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_