CROSSPOINT CHURCH

AWANA Medical & Media Release Form

Child's Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: Grade:

Parent(s) / Guardian(s)

Name(s): Cell Phone: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(\_\_\_\_\_)\_

Secondary Emergency Contact

Name:

Relationship to Child:

Home Phone: Cell Phone:

Insurance Company:

Policy #:

Allergies to Drugs, Foods, Plants, other:

I give permission for any necessary aid to be given immediately to my child if he/she should become injured or sick, including that given by EMS or a hospital emergency room staff, when a parent/guardian cannot be contacted. I also give permission for photos that include my child to be used solely for CrossPoint purposes. [Please note that NO names will be identified on photos!]

Parent/Guardian Signature Date