

**Santa Clara First Baptist Church  
2008-2009 AWANA Registration Form**

1. Child's name \_\_\_\_\_  
    Birthday \_\_\_\_\_ Grade in School \_\_\_\_\_  
Name of School \_\_\_\_\_  
Name of Church (Circle one):      SCFBC      Other      None  
If "Other," which church? \_\_\_\_\_

2. Child's name \_\_\_\_\_  
    Birthday \_\_\_\_\_ Grade in School \_\_\_\_\_  
Name of School \_\_\_\_\_  
Name of Church (Circle one):      SCFBC      Other      None  
If "Other," which church? \_\_\_\_\_

3. Child's name \_\_\_\_\_  
    Birthday \_\_\_\_\_ Grade in School \_\_\_\_\_  
Name of School \_\_\_\_\_  
Name of Church (Circle one):      SCFBC      Other      None  
If "Other," which church? \_\_\_\_\_

**FAMILY INFORMATION**

Parent/Guardian names: \_\_\_\_\_

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

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

Phone number: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

Emergency Contact Name \_\_\_\_\_

Emergency Contact Number \_\_\_\_\_

Where parents/guardians will be during AWANA:

- Home
- EDGE Worship Service
- Other (please specify): \_\_\_\_\_

## MEDICAL PERMISSION FORM

The information below will only be used for off-campus events, or when parents/guardians or emergency contact people are unavailable.

I hereby give permission to Santa Clara First Baptist Church personnel to obtain medical treatment for my child(ren) in an emergency situation in case of accident or acute illness. Any qualified physician may treat and do what is necessary for the health and well-being of my child(ren). It is understood that a conscientious effort will be made to notify me before such action is taken.

I also agree to accept responsibility for the cost of any necessary medical services.

1. Child's name \_\_\_\_\_

Medical insurance provider \_\_\_\_\_

Policy ID # \_\_\_\_\_

2. Child's name \_\_\_\_\_

Medical insurance provider \_\_\_\_\_

Policy ID # \_\_\_\_\_

3. Child's name \_\_\_\_\_

Medical insurance provider \_\_\_\_\_

Policy ID # \_\_\_\_\_

Parent/Guardian name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Any health issues we should know about? Describe below: