

Redwood Valley Community Church's



Dues: <input type="checkbox"/> Pd.in full	<input type="checkbox"/> Pmt. amt. _____
Uniform Sz. _____	<input type="checkbox"/> Vest <input type="checkbox"/> T-shirt
<input type="checkbox"/> Handbook	<input type="checkbox"/> Handbook Bag
<input type="checkbox"/> CD	<input type="checkbox"/> Other _____
Staff Use	

Registration 2018-19 Club Year

Name: _____

Birthdate: ____/____/____ Age: _____ Grade: _____ M F

Club: **Cubbies** (3 1/2 & 4 yrs. old – this includes TK)*: 1st year 2nd year
**Child should be entering Kindergarten within two years from start of Cubbies & must be potty trained.*
 Sparks (K- 2nd grade – does not include TK) 1st year 2nd year 3rd year
 T&T (3rd - 6th grade) 1st year 2nd year 3rd year 4th year

Address: _____

Mailing if different: _____

City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-Mail _____

Mother/Guardian: _____

Occupation: _____ Work Phone: _____

Father/Guardian: _____

Occupation: _____ Work Phone: _____

Child lives with: Both Parents Mother Father Other describe: _____

Name of Family's Church Affiliation: _____

Member Regular Attender Occasional Do not attend

Siblings attending club: _____ Age: _____

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I do not give permission for club year photos of my child to be used for church website or publicity.

TO WHOM IT MAY CONCERN:

As a parent and/or guardian, I do herewith authorize treatment under the direction of any licensed physician of the following minor in the event of a medical emergency, which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed.

This authority is granted only after a reasonable effort has been made to reach me by phone at the number listed below.

The undersigned assumes the responsibility for any costs connected with such treatment and hereby releases Awana Clubs International and Redwood Valley Community Church.

Name of Clubber: _____

Mother/Guardian: _____

Father/Guardian: _____

Address _____ City _____ Zip _____

Phone _____ Cell: _____ Work: _____

Family Physician Name: _____

Address: _____ Phone _____

Medical Insurance Company: _____ Policy # _____

Specific medical allergies, chronic illnesses, or other conditions:

Date of last tetanus shot: _____

Other contact in case of emergency:

Name _____ Phone _____

Relationship _____

THIS RELEASE FORM IS COMPLETED AND SIGNED OF MY OWN FREE WILL AND
WITH THE SOLE PURPOSE OF AUTHORIZING MEDICAL TREATMENT UNDER
EMERGENCY CIRCUMSTANCES IN MY ABSENCE.

Signed _____

Relationship to Clubber _____ Date _____