Saturday, September 23, 2017

Rock Chinese Church of Austin AWANA Registration Form

Name: ___________________________ Sex (circle one): Male Female

Address: ______________________________________ City: ________ State: TX
Zip code: _______________ Phone Number: __________________
Age: ______ Grade (2017 – 2018): _____ Birthday: _______________
Father's Name: ___________________________________ Christian: Yes No
Mother's Name: __________________________________ Christian: Yes No
RCCA fellowship (if any): _____________________________
E-mail (for announcement purposes) ____

Please check Club to Attend:

_____ Cubbies (pre-K 3 – 5 years old)	_____ Sparks (K – 2nd)	_____ T & T (**3rd – 5th**)

Please make checks payable to: Austin Chinese Church on memo line write AWANA.
Payment Due: ___ $20.00 Early Registration Fee before 10/22
___ $25.00 Regular Registration Fee after 10/22
___ $5.00 discount if parent or siblings volunteer as a full time helper

---

AWANA Indemnity and Medical Treatment Authorization

INDEMNITY AGREEMENT
As the undersigned as parent or legal guardian of the child listed above, does hereby give permission for the above name individual to participate in AWANA at Austin Chinese Church. As a condition of attending, I do hereby release Austin Chinese Church from any and all claims, demands, actions, or causes of action due to death, injury, or illness, in any way, arising from participating in AWANA, including to, but not limited to transportation to and from the sponsored event. **I further agree that the financial responsibility for securing care, in the case of injury resulting from participation in the program, is a matter between the participant and his/ her health care provider, and that Austin Chinese Church cannot pay health care providers for treatments of any injuries. It is further agreed, that the participant will assume all legal responsibility for their personal safety and actions while participating in the program and while traveling to and from the sponsored events.**

AUTHORIZATION FOR MEDICAL TREATMENT
I hereby authorize the treatment, administration of anesthesia, surgical treatment for my child listed above, in the event of a medical situation occurring in my absence when the hospital or physicians are unable to contact me. This authorization is rendered in the physician(s) care. **I hereby release the medical responsibility and liability the hospital, physician(s) and nursing personnel for performing medical procedures and acting on the authority of this medical treatment consent form which such medical providers deem necessary for my child.**

By checking off the boxes you are adhering to understand the agreement stated above:

____ INDEMNITY AGREEMENT ____ Authorization for Medical Treatment

Signature: ____ **Date** _______________

Information relating to conditions, allergies or medications, about which emergency medical personnel should be told: ____
Physician Name:__________________________________ Physician Phone: _______________
In an emergency, also contact:
Name: ____________________________________ Phone: _____________
Relationship: _________________________________

For Office Use Only
Unique Number: ___________
Payment Method:
____ Cash ____ Check
Check number: ____________
Payment Date:
____