

**ANTIOCH BAPTIST CHURCH – CHAPEL HILL, NC**  
**AWANA Emergency Information Form**

Date Completed: \_\_\_\_\_

**INSTRUCTIONS TO PARENTS:**

1. Compare all items on this side of the form. Sign and date where indicated.
2. If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

**Child's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**When parents cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:**

1) Name: \_\_\_\_\_

Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_ (Pager) \_\_\_\_\_

Address \_\_\_\_\_  
Street/Apt. # City State Zip Code

2) Name: \_\_\_\_\_

Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_ (Pager) \_\_\_\_\_

Address \_\_\_\_\_  
Street/Apt. # City State Zip Code

3) Name: \_\_\_\_\_

Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_ (Pager) \_\_\_\_\_

Address \_\_\_\_\_  
Street/Apt. # City State Zip Code

In **emergencies** requiring immediate medical attention, your child will be taken to the **Nearest Hospital Emergency Room**. Your signature authorizes the responsible person from Antioch Baptist Church in Chapel Hill, North Carolina to have your child transported to that hospital and receive treatment.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**ANNUAL UPDATES** \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_  
(Initials/Date) (Initials/Date) (Initials/Date) (Initials/Date)

**INSTRUCTIONS TO PARENT:**

- (1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
- (2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medical Condition(s) \_\_\_\_\_

\_\_\_\_\_

Medications currently being taken by your child: \_\_\_\_\_

\_\_\_\_\_

Date of your child's last tetanus shot: \_\_\_\_\_

Allergies/Reactions: \_\_\_\_\_

\_\_\_\_\_

**EMERGENCY MEDICAL INSTRUCTIONS:**

(1) Signs/symptoms to look for: \_\_\_\_\_

\_\_\_\_\_

(2) If signs/symptoms appear, do this: \_\_\_\_\_

(3) To prevent incidents: \_\_\_\_\_

\_\_\_\_\_

-----

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Note to Health Practitioner:**

If you have reviewed the above information, please complete the following:

\_\_\_\_\_  
Name of Health Practitioner Date

\_\_\_\_\_  
Signature of Health Practitioner (\_\_\_\_\_) Telephone Number