Permission Slip/ Medical Release

EVENT/ACTIVITY:
DATE (S):
PLACE:
TRANSPORTATION:

Child's Name ____

Person to Notify ____
Phone ___________________________ Cell ___________________________

In the event of an emergency where medical treatment is required, I give my permission to the Church staff or sponsor to obtain the services of a licensed physician. Please attempt to notify me immediately concerning any such emergency.

I, ____, hereby affirm and agree that I am the parent or legal guardian of ____, a minor ("Minor"); that I am legally competent to sign this agreement and release; that I have fully informed myself of this agreement by reading it and signing; and that I have fully informed myself of the details and risks of the Activity prior to signing this release.

I agree, individually and on behalf of Minor, to release and to hold harmless Church on the Rock, its agents, officers, directors and employees (collectively referred to as "the Church") from liability of any kind, for Minor's injury, death or damage to or loss of Minor's personal property, resulting directly or indirectly from his/her participation in the Activity or from the Church's negligence. I personally assume all risks and liabilities in connection with Minor's participation in the activity and agree to indemnify the Church from any liability assessed against the Church as a direct or indirect result of Minor's participation in the Activity. This release includes all risks and liabilities connected with the Activity, whether foreseen or unforeseen.

In the event that Minor is injured during the Activity, and I am unable to provide consent to his or her medical treatment, I authorize the Church to consent on my behalf to the performance of any and all medical treatment judged necessary by the Church, until I am able to provide consent or until someone legally able to speak on Minor's behalf is made available. I agree, individually and on behalf of Minor, to release, indemnify, and hold the Church harmless from any liability which may be assessed against the Church as a direct or indirect result of said medical treatment. I agree to pay or arrange for payment for all costs associated with said medical treatment.

____ ________________________
Signature of Parent or Guardian Date

Health Insurance Carrier ____
Policy Number ____

MEDICAL UPDATE

Birth date ____
Last Tetanus shot ____
Current medications ____
Allergies ____
Special medical instructions ____
(use other side, if necessary) ____

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