Christchurch Baptist Fellowship
Medical & Liability Release Form

Teen's Name _____ Phone _____

Address/ City/ State/ Zip _____

Date of Birth _____

I, the undersigned parent or legal guardian of the child named above, do hereby grant my permission and consent for the said child to attend and participate in the activities sponsored by Christchurch Baptist Fellowship, both on and off the grounds, including the necessary transportation to and from these activities.

Permission is granted for my child to receive medical care if: (1) such care is deemed necessary by the persons in charge of the event; (2) the proposed medical treatment or procedures are immediately or imminently necessary and any delay occasioned by an attempt to obtain my parental consent would reasonably jeopardize the life, health, or well-being of the child affected; (3) I cannot be personally contacted.

I further agree not to hold Christchurch Baptist Fellowship or any of its paid staff or volunteers responsible for any accident that may occur on the way to, from, or during any event. I indemnify, defend and hold harmless Christchurch Baptist Fellowship for all claims made and liabilities assessed against them as a result of any event or activity. I release CBF and all medical providers from liability in acting on my behalf in this regard and rendering such medical treatment. I assume the risk and financial responsibility for any injury resulting from any activity.

Furthermore, I understand and assume the expenses of any property damage caused by my child. Should it be necessary that my child be returned home due to disciplinary action, I will be contacted by the leaders and will be responsible to pick my child up and assume the cost of transportation and damages.

By signing below, I am acknowledging that I have read through and understand the above statements.

_____ _____

Signature of Parent or Guardian Date

In Case of Emergency, Please Contact:

1. Name _____ Phone _____

   Relationship to Teen _____

2. Name _____ Phone _____

   Relationship to Teen _____

Medical Information:

Physician _____ Phone _____

Medical Insurance Company _____

Policy # _____ Member's Name _____

Allergies / Meds _____

Other _____