PARTICIPANT WAIVER, MEDICAL RELEASE,
AND INDEMNITY AGREEMENT
Christian Campus Fellowship
PO Box 1141, Tallahassee, FL 32302 - 850-224-1958

Ministry Director: **Kane Miller**

Participant_____

Permanent Address of
Participant_____

Local Address of
Participant_____

In consideration of your accepting me for participation in any official Christian Campus Fellowship programs, sports, or activities, including but not limited to, mission trips and retreats, I hereby, for myself, my heirs, executors, and administrators, waive and release any and all rights and claims for damages that I may have against the above-named organization and its agents, employees, representatives, successors and assigns for any and all injuries suffered by myself that arise out of any official Christian Campus Fellowship programs, sports, or activities.

I warrant that I have the right to authorize the foregoing and do hereby agree to hold the above-named organization harmless of and from any and all liability of whatever nature which may arise out of or result from such participation.

For the consideration stated above, I further agree that in the event that I should make any claim against the above-named organization for damages arising out of any official Christian Campus Fellowship sports, programs, or activities, I will personally indemnify, defend, and hold harmless the organization and its agents, employees, representatives, successors, and assigns against any and all loss and damage occasioned thereby, including attorneys fees. This document also serves as a **photo & video release** for me to appear in photographs and/or videos while participating in associated Christian Campus Fellowship events/activities for the purposes of promotion, publicity, or staff training.

I have read and understand this Agreement and have willingly placed my signature below as evidence of my acceptance of all the conditions contained herein.

Please complete the following for medical emergency care:

Name of emergency contact :_____ Relation: _____

Telephone:_____*(Day time)* _____*(Night)*

Is participant covered by personal/family medical insurance? __Yes __No

If yes, name of insurer:_____

Policy or group number:_____

Relevant medical conditions or allergies:
_____

Medications: _____ Date of Last Tetanus shot: _____

Signature:

Participant (Print) _____ Date _____