SafeChurch®

Youth Ministry

Release and Waiver of Liability Form

Minor Participation Authorization
and Consent to Emergency Medical Treatment Form

September 1, 2017 to August 31, 2018

I, the undersigned, certify that I am the parent or legal guardian of _____ (hereafter the "minor child").

I hereby give my consent to have my minor child participate in the Youth Ministry program and events/activities of **Faith Christian Reformed Church** .

I recognize that there are risks involved in participating in this activity and hereby assume all risk of injury, harm, damage, or death to my minor child in connection with his/her participation in this activity.

To the fullest extent permitted by law, I release **Faith Christian Reformed Church**, its trustees, officers, directors, employees, agents and representatives from any injury, harm, damage or death which may occur to my minor child while participating in the activity and agree to save and hold harmless **Faith Christian Reformed Church**, its trustees, officers, directors, employees, agents and representatives from any claims arising out of my minor child's participation in the activity.

Further, being the parent or legal guardian of the minor child, I do consent to any medical, surgical, x-ray, anesthetic, or dental treatment that may be deemed necessary for my minor child. I understand that efforts will be made to contact me prior to treatment but, in the event I cannot be reached in an emergency, I give permission to the activity leader to make the decisions necessary for treatment. Should there be no activity leader available, I give permission to the attending physician to treat my minor child. As parent or legal guardian, I understand that I am responsible for the health care decisions of my minor child and agree that my insurance plan is the primary plan to pay for the medical, dental, or hospital care or treatment that is given to my minor child. Any insurance policy of the church or organization sponsoring this event will be used as the secondary coverage.

Executed this _____ day of _____, 20__.

Signature _____

Printed Name _____

Witness: _____

Witness: _____

Please provide emergency contact information:

Name of Child:_____

Date of Birth: _____ Grade:_____

Address: _____

Street/City/State /Zip

Mother's Name: _____ Phone Number:_____

Father's Name: _____ Phone Number: _____

Email address: _____

In the event that the parent/guardian cannot be reached, please contact:

Name:_____ Phone Number:_____

Relationship to Child:_____

Additional comments regarding medical history, allergies, or drug reactions, etc. which may be needed in treatment:

_____

_____

_____

_____

Date of last Tetanus Shot:_____

Insurance Company_____ Policy #_____