CONSENT AND RELEASE WAIVER

Participant Name: _____

Please read the following document thoroughly and sign below in ink. This Consent and Release Waiver may be revoked by the undersigned at any time before the expiration date with written notice to the Organizer.

The undersigned being lawful parent(s) and/or guardian(s) of the above-named Participant (the "Participant"), hereby consents to the participation by the Participant in all events or programs ("Activities") that are conducted by and/or participated in by Fellowship Baptist Church, 2827 E 32nd Street, Joplin, MO 64804 [417-781-5174] (the "Organizer"), that occur between the dates of **September 1, 2016 and August 31, 2017** (the "Activity Period").

The undersigned hereby further authorize(s) any of the staff, employees, agents and representatives of the Organizer to, on behalf of the Participant during the Activity Period, provide for, approve and authorize any health care at any hospital, emergency room, doctor's office or other institution; employ any physicians, dentists, nurses, or other person whose services may be needed for such health care; review and if necessary disclose the contents of any medical records; execute any consent form required by medical, dental or other health authorities incident to the provision of medical, surgical or dental care to the Participant. Health care shall include but not be limited to the administration of anesthesia, X-ray examination, performance of operations, diagnostics and other procedures. Notwithstanding other provisions in this Consent and Release Waiver, the Organizer is not hereby granted the authority to withhold or withdraw life-sustaining procedures for the Participant.

The undersigned assume(s) all risk of injury or harm to the Participant associated with or rising from participation in any Activities during the Activity Period, and hereby agrees to release, indemnify, defend and forever discharge Organizer and its staff, employees and agents of and from all liability, claims, demands, damages, costs, expenses, actions and causes of action (collectively the "Claims") in respect to death, injury, loss or damage to the Participant or by the Participant, however caused, arising from the Participant's participation in any Activities during the Activity Period.

The undersigned grants Organizer permission to photograph or videotape Participant during the Activity Period, and hereby grants Organizer unlimited permission to use said photographs or video of Participant for any lawful purpose.

The undersigned hereby states that the information on the reverse side of this document is factual and accurate to the best of the undersigned's knowledge.

_____ _____

Date Signature of Participant or Parent/Guardian if Under 18

_____

Printed Name of Participant or Parent/Guardian if Under 18

FELLOWSHIP BAPTIST CHURCH

Worshipping Jesus, Following Jesus, Sharing Jesus... TOGETHER!

2827 E. 32nd St. • Joplin, MO 64804 • 417-781-5174

www.fellowshipjoplin.org

General Information

Please Print in Ink

Student Name: _____
Last First Middle

Male ❑ Female ❑ Birthdate _____ Grade _____

Address _____ City _____ State ____ Zip _____

Home Phone ( ) _____ Family E-Mail _____

Father's Name _____ Contact # ( ) _____ Cell ❑ Work ❑ Text ❑

Mother's Name _____ Contact # ( ) _____ Cell ❑ Work ❑ Text ❑

How would you like to receive information and updates? Phone ❑ E-Mail ❑ Text ❑ Facebook ❑

Do you attend church? Yes ❑ No ❑ If so, where? _____

If either parent cannot be contacted, please contact _____ Relationship _____

Primary Phone ( ) _____ Alternative Phone ( ) _____ Cell ❑ Work ❑

The following people are allowed to pick up my child: _____

_____

Medical Information

Please Print in Ink

Medical Insurance Company _____ Policy # _____

Policy Holder's Name _____ Date of Birth _____ SS # _____

Primary Physician _____ Office Phone ( ) _____

Please answer each question, use the space below to explain. If you mark yes or check any box, please write the number of the question and the explanation on the lines provided below.

1. Does your child have any allergies? ❑ Pollens ❑ Medications ❑ Food ❑ Insect Bites ❑ Other _____
2. Does your child suffer from, ever experienced, or is currently being treated for any of the following?
   ❑ Asthma ❑ Heart Trouble ❑ Diabetes ❑ Migraines/Severe Headaches
   ❑ Physical Handicap ❑ Frequently Upset Stomach ❑ Epilepsy/Seizure Disorder
3. Does your child wear: ❑ Glasses ❑ Contact Lenses
4. Has your child had any major medical conditions, illnesses or surgeries in the last year? ❑ Yes ❑ No
5. Does your child have any on-going medical conditions, diseases, or disabilities? ❑ Yes ❑ No
6. Is your child taking any on-going medications? ❑ Yes ❑ No
7. Is there any reason that your child's activities should be restricted? ❑ Yes ❑ No
8. Is Tetanus Shot Current? ❑ Yes ❑ No If So, Date of Last Tetanus _____

Explain _____

_____