

## Brock Baptist Church Student Ministry Medical & Liability Release Form 2019

Student's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address/ City/ State/ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Event Name \_\_\_\_\_

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 events and activities of Brock Baptist Church Student Ministry, both on and off church grounds, including the necessary transportation to and from these events and 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 Brock Baptist Church or any of its paid staff or volunteers responsible for any accident that may occur on the way to, from, or during an event. I indemnify, defend and hold harmless Brock Baptist Church for all claims made and liabilities assessed against them as a result of any event or activity. I release Brock Baptist Church 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 event or 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 (when on trips), I will be contacted by the leaders and will be responsible to pick my child up and assume the cost of transportation.

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 Student \_\_\_\_\_

2. Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to Student \_\_\_\_\_

**Medical Information**

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Medical Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_ Member's Name \_\_\_\_\_

Allergies / Meds \_\_\_\_\_

Other \_\_\_\_\_