

Additional comments:

Signature of medical release for persons under the age of 18.

Should this participant's activities be restricted for any reason? Please explain:

I, the student, have read the above evaluation of my health, and I agree to abide by the stated personal limitations.

Student signature: _____ Date: _____

I/We the undersigned have legal custody of the student named above, a minor, and have given our consent for him/her to attend events being organized by the Church, which include weekly activities, special trips and events, etc. In the event that he/she is injured in a ministry setting and requires the attention of a doctor, I/we consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is required from a physician and/or hospital personnel designated by the Church, I/we agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. I/We also acknowledge that we will be ultimately responsible for the cost of any medical care that is not reimbursed by our health insurance provider. Further, I/we affirm that the health insurance information provided above is accurate at this date and will, to the best of my/our knowledge, still be in force for the student named above. I/we also agree to bring my/our child home at my/our own expense should they become ill or if deemed necessary by a ministry staff member.

Parent/guardian signature: _____ Date: _____

Signature of medical release for persons over the age of 18.

In the event that I am injured and require the attention of a doctor, I consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is required from a physician and/or hospital personnel designated by the Church, I agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. I also acknowledge that I will be ultimately responsible for the cost of any medical care that is not reimbursed by my health insurance provider. Further, I affirm that the health insurance information provided above is accurate at this date and will, to the best of my knowledge, still be in force for me. I also agree to go home at my own expense should I become ill or if deemed necessary by a ministry staff member.

Signature _____ Date _____

Notarization

Notarization County of: _____ State of: _____

Before me the undersigned authority, on this day personally appeared _____, Known to me to be the person whose name is subscribed above, and acknowledged to me that he/she executed the same for the purpose therein expressed. Sworn and subscribed before me the _____ day of _____, 20____.

Notary Public