COMMUNITY PRESBYTERIAN **CHURCH**

CPC **STUDENTLIFE**

222 W EL PINTADO ROAD, DANVILLE, CA 94526 (925) 837-5525 CPCDANVILLE.ORG

STUDENT PARTICIPANT'S WAIVER, MEDICAL RELEASE, AND INDEMNITY AGREEMENT

Please read every part of this Agreement carefully. Your signature indicates that you understand and agree to every aspect of this document. This Agreement applies to ALL ACTIVITES sponsored by Community Presbyterian Church, its Student Ministries program, and its Staff, regardless of location, throughout the following period of time:

January 1st 2022 to December 31st 2022

Student's Full Name:

(first)_____ (middle)_____ (last)_____

Date of Birth: _____

Address: _____

City: _____ ZIP: _____

Student's Cell Number: _____

High School Graduation Year: _____ School: _____

Parent/Guardian Name: _____

Parent Cell Phone: _____

Parent Email: _____

Medical Insurance Carrier / Plan Name:

_____

Policy Number: _____

Name & Phone of Primary Doctor:

_____

Medications Taken	Dosage/Frequency
_____	_____
_____	_____
_____	_____

Allergies or Special Concerns:

_____

_____

_____

Please don't miss the next page!

I,_____, the parent or legal guardian of the above-named minor, hereby give my permission for his/her participation in the youth activities/events/ programs sponsored by Community Presbyterian Church.

I agree to direct my child to cooperate and conform to directions and instructions of personnel responsible for all related activities/events/programs. I agree that in the event my child is injured as a result of his/her participation in the above-named activities/events/programs, including transportation to and from these activities, whether or not caused by the negligence (active or passive) of the activity or the church program, or any of its agents or employees; recourse for the payment of any hospital, medical , dental, or related costs and expenses will be paid either by me or my spouse, accident, hospital or medical insurance, or any available benefit plan of mine or my spouse.

I consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physical, surgeon, and dentist licensed under the Medical Practice Act and Dental Practice Act. As parent or legal guardian, I am responsible for the health care decisions of my child and am authorized to consent to services to be rendered, and no other consent is required by law.

I hereby give permission to the physician selected by the activities supervisory personnel then present to render medical treatment deemed necessary and appropriate by the physician or dentist.

I also understand that if at any time my child is behaving in an inappropriate manner, is unwilling to follow the instructions of those leading the above mentioned activities/ events/programs, or is found under the influence or in possession of drugs, alcohol, or a weapon **it will be my responsibility to pick up my child or to pay the expenses of having my child sent home.**

_____ _____

Parent or Legal Guardian Signature Date

_____ _____

Print Name of Parent or Legal Guardian Relationship to student