

# COMMUNITY PRESBYTERIAN CHURCH STUDENTLIFE

Community Presbyterian Church 222 West El Pintado Danville, CA 94526 (925) 837-5525

## Student Participant's Waiver, 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 ACTIVITIES sponsored by Community Presbyterian Church, its Student Ministries program, and its Staff, regardless of location, throughout the following period of time:**

**January 1<sup>st</sup> 2019 to December 31<sup>st</sup> 2019**

Student's Name:

(first) \_\_\_\_\_ (middle) \_\_\_\_\_ (last) \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Student's Cell Number: \_\_\_\_\_

High School Graduation Year: \_\_\_\_\_

School: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

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 back! →**

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