

Permission Slip/Waiver & Indemnity Agreement & Authorization for Medical Treatment Form

Name of Participant: _____

(Please print)

For (Name of Event or Trip): Youth Winter Fest Date: January 5-7, 2018

City: Mt. Bethel State: PA

In consideration of your accepting me or my child for participation in the above named program, activity or sport, I hereby, for myself, my heirs, executor and administrators, waive and release any and all rights and claims for damages that I may have against the above named organization and its agents, employees, representatives, successors and assigns for any and all injuries suffered by myself or my child that arise out of the above named program, activity, or sport sponsored by the above named organization.

I warrant that I have the right to authorize the foregoing and do hereby agree to hold the above-named organization harmless of and from any and all liability of whatever nature, which may arise out of or result from such participation.

For the consideration stated above, I further agree that in the event that my child or I should make any claim against the above-named program, activity or sport, I will personally indemnify, defend or hold harmless the organization and its agents, employees, representatives, successors and assigns against any and all loss and damage occasioned thereby, including attorney's fees.

Authorization for Medical Treatment

This release and consent give Shelter Rock Church (SRC) permission to take my child to the nearest available medical facility and have any necessary emergency treatment administered.

I understand that every effort will be made to contact me. However, in case of emergency, if I cannot be reached, I hereby give SRC permission to act on my behalf in seeking medical treatment by qualified personnel for my child in the event that such treatment is deemed necessary or advisable for my child's health, safety and welfare. I release SRC, it's staff (paid or volunteer), and all medical providers from liability in acting on my behalf in this regard rendering such medical treatment.

Note: I understand that my personal insurance is primary. I have read and understand this agreement.

I have read and understand this Agreement and have willingly placed my signature below as evidence of acceptance of all the conditions contained herein.

Current Medical Condition

List **any and all** medical conditions, allergies, of medical limitations that the child may be experiencing or has experienced in the past.

Current Medications (Medications must be sent with participant in their original containers.)

Medication name	For	Dosage
_____	_____	_____
_____	_____	_____

Health Insurance Co.: _____ Group No.: _____ Phone #: _____

Insured under whose name: _____ S.S.# of insured: _____

Participant's Doctor: _____ Phone #: _____

In an emergency, you may call the person listed below in the event a parent cannot be reached.

Name: _____ Phone: _____

SIGNATURES

By signing you agree that the above statements are true and that you agree to abide by all of the rules and guidelines as set forth by SRC.

Participant: _____ Date: _____

Parent/ Guardian: _____ Date: _____

Print Parent/Guardian Names: _____ Cell #: _____

Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____