Christ Central Presbyterian YOUTH

PERMISSION/MEDICAL RELEASE FORM

2020-21

Name____**Phone**_____________________

Address____**City/Zip**______________________

School____ **Current Grade** __________________

Date of Birth___/___/___**Guest? N Y Invited by**_______________________________

Emergency Contact_________________________ **Relationship**_________ **Phone**________________

I give permission for my child to join Christ Central Presbyterian Church on their activities and/or programs from September 1, 2020-August 31, 2021. I also give permission for my child to be transported in a vehicle by a staff member or volunteer of Christ Central Presbyterian. I understand at certain events there may be opportunity to swim in a pool or lake and though a responsible adult will be supervising, a certified lifeguard may or may not be present.

Knowing the above I give my child permission to swim (check one) ___YES ___ NO

I hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify Christ Central Presbyterian Church and its officers, staff, volunteers, and/or anyone else involved with said organization from any and all claims, actions, or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my child's (or my) use of any and all equipment, my child's (or my) participation in any and all activities and/or programs, and/or my child's (or my) involvement in any and all modes of transportation. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future for the negligent acts or other conduct by officers, staff, volunteers, or any person involved with Christ Central Presbyterian Church.
In the event of an emergency, I hereby authorize an adult leader of the activity, as an agent for me, to consent to any medical or dental examination and subsequent treatment as advised by a licensed medical practitioner. I expect to be contacted as soon as possible about any such medical problems.

Medical Information

Allergies/Medical Conditions:____

Current Medications____

Medical Insurance Company____

Policy #______________________________**Insured's Name**___________________________

Please include a copy of your insurance card.

Signature of parent/legal guardian X_______________________________**Date**___/___/___
Must Have Signature Notarized

(print name) ____

In witness Whereof, we have set our hand and seal this ____ day of ______________, 20___.

State of____________
County ____________

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Notary