GRACE FIRST PRESBYTERIAN CHURCH

Liability/Release Form

I, _____(participant's name), in consideration of the benefits derived from my participation in the following event:

_____

_____

administratively organized by Grace First Presbyterian Church, do hereby voluntarily release, quit, and forever discharge Grace First Presbyterian Church and its officers, employees, and agents from all manner of suits, actions, claims, demands, and liabilities which may arise from my participation in this event.

I recognize that the conditions in some of the places to which I will travel are not of the same standards as the conditions to which I am accustomed. I realize further that there are certain health risks, as well as other risks to me and my property; and I enter into participation in the trip with the knowledge of those risks.

I understand that this document constitutes a full and complete waiver of all possible claims, including claims for negligence in personal property damages arising out of my participation in this event.

No provision of this document shall in any way limit my right to make claims against persons other than Grace First Presbyterian Church, its officers, employees, and agents.

Participant's Signature_____

(*If under 18*) Parent/Guardian
Signature_____

Consent For Medical Care Consent For Medical Care

(I/We), the undersigned , parent/guardian of (If under 18)_____, a minor, do hereby authorize the persons presenting this form to call a physician and to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable for (my/our) child.

It is understood that a conscientious effort must be made to notify (me/us) before such action is taken. It is further understood that we release the person presenting this form from all liabilities connected with the transportation, diagnosis treatment, hospital care, and expenses necessary for the treatment of (my/our) child.

This authorization is given pursuant to the provisions of section 25.8 of the Civil Code of California.

Parent's Signature: (If under 18)_____ Date: _____

Cell Phone: (____)_____ Home Phone: (____)_____

Email Address: _____

Address: _____

City: _____ State:_____ Zip:_____

Medical Information **(All participants must fill out)**

Carrier: _____ Policy #: _____ ___

Physician To Be Called: _____ Phone: (____)_____

Address: _____

City: _____ State:_____ Zip:_____

If the physician cannot be reached, what action should be taken? _____

Date of Birth: _____ Allergies: _____

Medications: _____