Upryzing Student Ministries

Harvest Time Church - Release of Liability

PLEASE RETURN FORM BY SEPTEMBER 29TH
PLEASE PROVIDE PAYMENT WITH FORM. COST: $135
ADDITIONAL ACTIVITIES: PAINTBALL $30 / HIGH ROPES $30

The purpose of this form is to provide information in the event of an emergency, permission to seek medical treatment, and parent consent to do so.

Name and date of event: Youth Retreat October 14-17

Youth's Full Name: _____

Birthdate: _____ Grade in School: _____

Parents'/Guardians' Names: _____

Home address: _____
Street City State Zip code

Phone: _____
Mother: Home / cell Father: Home / cell

Alternate Emergency Contact: _____
Name and Phone #

Health Plan Carrier: _____
Policy #_____ Insurance Agent Phone #_____
Policy Holder's Name_____

We (I) the parents/guardians of _____ a minor, after failed attempts to contact us (me) do hereby authorize my/our child's group leader or youth councilor of Harvest Time Church to consent to any x-ray, anesthetic, medical, surgical, and dental diagnostic or treatment as may be considered necessary by the physician, surgeon, dentist or other health care personnel for such minor child. The undersigned shall be liable and agree(s) to pay all cost in connection with medical treatment of our (my) child. We (I) further release Harvest Time Church and any members of its governing boards and committees, pastors, employees, staff counselors, and volunteers acting on behalf of and of the above, for any and all

liability, claims, suits, cause of action and demands, at law or in equity, and however arising, for personal injuries and damages which may be incurred by our child and/or ourselves while such child attends, participates in, or travels to and from, any youth activities sponsored by, or affiliated the youth ministry program of Harvest Time Church

EMERGENCY MEDICAL INFORMATION

General: Does participant have: (if "yes" explain)

Allergies? ____ Yes ____ No _____
Heart Condition? ____ Yes ____ No _____
Other? _____

Does participant have reaction to: (if "yes" explain)
Bee Sting? ____ Yes ____ No _____
Penicillin? ____ Yes ____ No _____
Other Drugs? ____ Yes ____ No _____

Has the participant had any serious illness or surgery within the past ten years?
____ Yes ____ No (if "yes" explain)
_____
_____

Does the participant have any condition that would prevent him/her from participating in any activities? Please list:

I agree that I have read and understood all of the above information and provide accurate information about my student's medical history as requested on this form.

Signature of Parent /Guardian:_____ Date: _____

Signature of Parent/Guardian: _____ Date: _____