

CALVARY COMMUNITY CHURCH

PO Box 39607, Phoenix, AZ. 85069. Phone 602-973-4768 Fax 602-789-7165

CONSENT RELEASE FORM

I give consent for _____ to participate in the _____ with Calvary Community Church **Fellowship Adventures** ministry on _____. I assume all the risks and hazards incidental to such participation including transportation to and from the activity, and do hereby waive, release, absolve, indemnify and agree to hold blameless the staff, sponsors, participants and persons transporting me or my child to and from the activity for any claim arising out of injury to me or my child.

Participant or Parent/Legal guardian's signature _____ Date _____
Print name _____ Relationship to child _____
Address _____ Phone _____

MEDICAL INFORMATION

PLEASE NO REFRIGERATED MEDICATIONS OR VITAMIN SUPPLEMENTS

Allergies _____ Allergic reactions _____
Current medication (including contacts) _____
Date of last Tetanus shot _____
Other information or instructions _____

IN CASE OF EMERGENCY, CALL:

Name _____ Phone _____ Relationship _____
If above cannot be contacted, call
Name _____ Phone _____ Relationship _____

NAME OF MAIN POLICY HOLDER _____
Policy No. _____
Name of Insurance Company _____
Insurance Company Address _____

*****Be sure to sign the medical release form on the back*****

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MEDICAL RELEASE

In case of injury or illness to my child and I am unable to be contacted; or in case of injury or illness to myself and I am unable to respond for medical attention,

Name (Must be 21 years or older)

Phone

is an authorized agent for the undersigned to consent to X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general supervision of any licensed physician or surgeon on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of aforesaid agents to give specific consent to any and all diagnosis, treatment or hospital care, which the aforementioned physician in the exercise of his/her best judgment may deem advisable.

Participant's name (Printed)

Participant's signature

Date

Parent/guardian's signature

Date

Be sure to complete the other side of this form.