HOPE COMMUNITY

Liability Release & Medical Permission

Hope Youth - Fun Trip to _____ (location) on _____ (date)

RELEASE OF LIABILITY:

1. In consideration of _____ (full name) being allowed to participate in activities sponsored by Hope Community Church, I do hereby release, forever discharge, and agree to hold harmless Hope Community Church of Willow Grove its employees, elders, staff, and adult leaders (including vehicle owners and drivers) from any and all liability, claims or demands for personal injury, sickness or death, as well as property damage and expenses, of any nature whatsoever, which may be incurred by the participant while participating in an activity sponsored by Hope Community Church. I understand that many of the activities will be physical in nature, will include travel, and will involve other youth and adult participants. I hereby assume all risk of personal injury, sickness, death, damage and expenses as a result of my participation in all activities involved therein.
2. I further agree to hold harmless and indemnify said church, employees, elders, staff, and adult leaders (including vehicle owners and drivers) for any liability sustained by said parties, including attendant costs and expenses, as the result of the negligent, willful or intentional acts of said participant.

_____ _____

Authorized Signature of Participant OR Parent/Guardian on behalf of Participant — Date

MEDICAL PERMISSION:

In case of emergency I hereby give permission for an adult sponsor to take me or my child _____ (full name) to a physician or medical facility and give permission for such medical provider to treat me or my child. I authorize all reasonable and necessary medical treatment, including, but not limited to, emergency surgery. I assume the responsibility of all medical bills. I also give an adult sponsor the authority to dispense any medications listed below.

_____ _____

Authorized Signature of Participant OR Parent/Guardian on behalf of Participant — Date

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MEDICAL INFORMATION:

Name of participant _____ Birth date _____ Weight _____
Home address _____ City/State _____
☐ Male ☐ Female | Age _____ Grade _____ Phone # ( ) _____
Father's name (if under 18) _____ Phone # ( ) _____
Mother's name (if under 18) _____ Phone # ( ) _____
Additional Emergency Contact (in case you cannot be reached):
Name _____ Phone # ( ) _____

1. Should a bill be sent to ☐ your insurance company, or ☐ directly to you?
2. Person responsible for the bill _____
3. Health Insurance Company and mailing address
   _____
   _____
4. If employer insured, list name/address of employer.
   _____
   _____
5. Whose name is the insurance in? _____
6. Health Insurance policy number _____ Group # (if any) _____
7. Doctor's name _____ Phone # ( ) _____
8. Allergic to any medicines? ☐ No ☐ Yes → List _____
9. Allergic to any foods? ☐ No ☐ Yes → List _____
10. Medical comments
    _____
    _____

If participant is under 18, list any medication needed along with directions. Please include all Over-the-Counter Meds. These medications need to be sent in original, labeled medication bottle.

_____ Advil
_____ Tylenol
_____ Antacids

Other _____
_____
_____

Please include a copy of your insurance card with this form.