

CCC MEDICAL CONSENT WAIVER AND INDEMNITY

As team member of a CCC activity or trip, I hereby provide medical and indemnity information to participate in the activities and events organized by CONCORD CHRISTIAN CHURCH. I understand that this is an annual requirement for my child. If at any time during the calendar year the below information changes, it is participant's responsibility to contact CONCORD CHRITSTIAN CHURCH to update said information.

Full Name _____
Last First Middle
Sex _____ Birthday _____ Age _____

Home Address _____

Home Phone _____ Cell Phone _____

In an emergency, notify:

1. Name _____ Phone (____) _____
Street Address _____
City _____ State _____ Zip _____

Or

2. Name _____ Phone (____) _____
Street Address _____
City _____ State _____ Zip _____

Does this participant have any of the following allergies?

Penicillin _____ Other: _____
Other Drugs _____
Insect Stings _____
Ivy Poisoning, etc. _____
Hay Fever _____

Does this participant have any medical or health problems, OR has the participant had any chronic or recurring illness or illnesses, which would have an effect on the child's participation in this activity? _____ Yes _____ No
If yes, describe the problems or illnesses _____

State the name, address, medical specialty and phone number of the participant's physician and of any other physician who should be consulted in the event of emergency or medical problems involving the participant:

State the name, address, and phone number of the participant's dentist (and orthodontist, if applicable):

Is there medical or hospitalization insurance which provides benefits for the participant? _____ If yes, please indicate:

Name of Insurance Company _____

Address _____

Policy No. of Insurance Policy _____

Name of Policy Holder _____

Phone # of Insurance Company _____

Are there any activities, such as strenuous activities, to be restricted for the participant? _____ If yes, describe: _____

Is the participant on any medications? _____ If yes, please state the medication: _____

If yes, will the participant be bringing to the Activity the medications that he/she should be taking? Please list

Describe any dietary restrictions that the participant is required to observe

Other comments or suggestions the participant deems important for this trip? _____

I understand that any personal medical and hospitalization insurance available to me will provide primary coverage. I agree to apply first for benefits from the personal hospitalization and medical coverage available to me, if any, before applying for benefits that may be available from the ministry's medical and hospitalization coverage.

By signing below, the participant acknowledges and accepts the risks of physical injury associated with participation in the activity described above. Except for gross negligence on the part of the sponsor, the participant accepts personal financial responsibility for any bodily or personal injury sustained during the activity. Further, the participant promises to hold harmless the sponsoring organization and its representatives for any injury related to the activity.

The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

Should it be necessary for me to return home due to medical reasons or otherwise, the undersigned shall assume all transportation costs.

Signature _____
(Participant)

Date _____

Print Full Name _____