

# CCC MEDICAL CONSENT WAIVER AND INDEMNITY

As parent or legal guardian, I hereby provide medical and indemnity information for my child 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 undersigned's responsibility to contact CONCORD CHRITSTIAN CHURCH to update said information.

Child's Full Name \_\_\_\_\_  
Last First Middle

Sex \_\_\_\_\_ Birthday \_\_\_\_\_ Age \_\_\_\_\_

Parent or Guardian Name \_\_\_\_\_

Home Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

If not available in an emergency, notify:

1. Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Or

2. Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Does this child have any of the following allergies?

Penicillin \_\_\_\_\_ Other: \_\_\_\_\_

Other Drugs \_\_\_\_\_

Insect Stings \_\_\_\_\_

Ivy Poisoning, etc. \_\_\_\_\_

Hay Fever \_\_\_\_\_

Does this child have any medical or health problems, OR has this child 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 this child's family physician and of any other physician who should be consulted in the event of emergency or medical problems involving this child:

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

Is there medical or hospitalization insurance which provides benefits for this child? \_\_\_\_\_ If yes, please indicate:

Name of Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

Policy No. of Insurance Policy \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_

Phone # of Insurance Company \_\_\_\_\_

Indicate the date of this child's last tetanus shot \_\_\_\_\_

Are there any activities, such as strenuous activities, to be restricted for this child? \_\_\_\_\_ If yes, describe: \_\_\_\_\_

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Is this child on any medications? \_\_\_\_\_ If yes, please state the medication: \_\_\_\_\_

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If yes, will this child be bringing to the Activity the medications that he/she should be taking? Please list \_\_\_\_\_

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Describe any dietary restrictions that this child is required to observe \_\_\_\_\_

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Other comments or suggestions from the parent or guardian concerning this child \_\_\_\_\_

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

I further understand that, in the event my child requires medical or dental treatment while engaged in the Activity, reasonable efforts will be made to contact me; however, if I cannot be reached, I hereby consent and give permission to the ministry's sponsor or any adult counselor acting on behalf of the ministry with respect to the Activity, as agent for me, to consent to any X-ray examination; injections; anesthesia, medical, dental or surgical diagnosis and treatment; and hospital care and treatment advised and supervised by a physician, surgeon, or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered, either as an outpatient or in any hospital. To the best of my knowledge, I have listed above all of my child's medical allergies, medications being taken, medical problems and other pertinent information. My child has permission to participate in all prescribed activities except as noted by me.

By signing below, the participant (or parent/guardian if participant is a minor) 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 (or parent/guardian) accepts personal financial responsibility for any bodily or personal injury sustained during the activity. Further, the participant (or parent/guardian) 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 our (my) child to return home due to medical reasons or otherwise, the undersigned shall assume all transportation costs.

Signature \_\_\_\_\_  
(Parent or Guardian)

Date \_\_\_\_\_

Print Full Name \_\_\_\_\_