CF Student Ministries | All Year Waiver Form | 2019-2020

I/We give consent for _____ (name of minor) to attend any event sponsored by Community Fellowship Student Ministries (CFSM) from August 1, 2019-August 30, 2020.

I/We give consent for CFSM to use a photo or other digital reproduction of _____ (name of minor) for publication processes, whether electronic, print, digital or electronic via the Internet.

In the event that he/she is injured while under the care of Community Fellowship and its representatives and requires the attention of a doctor, I/We hereby consent to and will be responsible for any reasonable medical treatment as deemed necessary (including injection, medication, anesthesia, surgery, hospitalization or such other medical practices) by a licensed physician.

I/We further agree to hold the licensed physician, the medical facility, Community Fellowship and its representatives free and harmless of any claims, demands, or suits for damage arising from the authorization and provision of such medical treatment.

I/We understand the nature of the event and so hereby release Community Fellowship and its representatives from any liability due to accident or injury incurred by my child.

I/We agree to cover all costs if our students need to be sent home for any disciplinary reasons.

I/We understand that all transportation will be provided by one or more of the following: (1) personal vehicle driven by parent or student ministry adult sponsor, (2) rented van driven by parent or student ministry sponsor, or (3) chartered bus.

Student Information:

Student Name_____ Home Phone_____ Cell Phone _____

Address_____City_____Zip_____

School_____Grade_____Birthdate_____

Father Name_____ Wk Phone_____ Cell Phone_____

Mother Name_____ Wk Phone_____ Cell Phone_____

Student E-mail _____

Parent E-mail _____

Allergies, medicines, or medical information that needs to be known about the student (continue on back if necessary):

_____

In case of emergency, call:

Name: _____ Relationship: _____ Phone _____

Medical Insurance Information: ***Please attach copy of insurance card, front and back.***

Physician Name: _____ Phone Number: _____

Insured Parent Name: _____ Insured Parent Employer: _____

Insurance Company: _____ Insurance Co. Phone #: _____

Insurance Co. Address: _____ City: _____ State: ____ Zip: _____

Policy #: _____ Group #: _____

Parent/Guardian Signature: _____

Parent/Guardian Print: _____

Date: _____