CARMEL BAPTIST CHURCH

RELEASE AND CONSENT FORM

2-06-13

I hereby, for myself, my heirs, executors, and administrators, waive and forever discharge any and all right and claims for damages which I may have or which may hereafter accrue to me against CARMEL BAPTIST CHURCH, their members, respective officers, agents, representatives, successors, and/or assigns, individually or collectively for any and all damages and liabilities which may be sustained and suffered by me in connection with my association with/or arising out of my traveling with, participation in, and returning from any activity sponsored by CARMEL BAPTIST CHURCH.

The person and others whose signature are attached below do hereby consent to any and all medical and surgical treatments including anesthesia and operations which may be deemed advisable by his or her physician and surgeons. I (we) understand that in the event medical treatment is required, every effort will be made to contact me. However, if I cannot be reached, I give my permission to the staff or sponsor to secure the services of a licensed physician to provide necessary care, including anesthesia, for my child's well-being.
In witness of our consent and agreement to the matters stated in the preceding sentences, we have subscribed our signatures below.

DATE: _____ **TRIP NAME** _____ **DATES OF TRIP** _____

DATE OF BIRTH _____ **YOUR PASSPORT NUMBER** _____

PARTICIPANT'S NAME: _____
Last Middle First

ADDRESS: _____
STREET CITY STATE ZIP

DAYTIME PHONE: _____ **EVENING PHONE**: _____

NAME OF EMERGENCY CONTACT: _____ Relationship _____
Address of Emergency Contact: _____
Home Phone: _____ Cell Phone: _____
Email _____
Work Phone: _____ Best way to reach this person: _____

SECONDARY INSURANCE INFORMATION:
Carmel Baptist Church will secure accident and injury insurance for each volunteer during the mission trip. The following information is needed to secure this insurance:

Beneficiary Full Name _____

Relationship to Beneficiary _____

MEDICAL INFORMATION:
List any current allergies, illnesses, physical conditions, or medications: _____
_____

Do you take any medication on a regular basis? ___Yes ___ No

If yes, please describe _____
(If you are on medication during this trip, please notify the adults in charge)

Is sponsor authorized to approve medical treatment? ___ Yes ___No

Is participant covered by personal/family medical insurance? ___Yes ___ No

If yes, Name of Insurer: _____ Policy or Group Number _____

Primary Care Physician: _____ Phone _____

_____ _____
Signature of Applicant **Date**

_____ _____
Signature of Parent (if applicant is under 18 years of age) **Date**