

**Carmichael Presbyterian Church Student Ministries Emergency Form
Authorization for Medical Treatment & Liability**

(Please Print)

Name of Event _____ Date of Event _____
Participant's Name: _____ Date of Birth _____
Parent/Guardian: _____ Relationship _____
Emergency Contact: _____ Phone (____) _____

Authorization for Medical Treatment

This release and consent gives CPC Student Ministries permission to take my child to the nearest available medical facility and have any necessary emergency treatment administered.

I understand that every effort will be made to contact me. However, in case of an emergency, if I cannot be reached, I hereby give CPC permission to act on my behalf in seeking medical treatment by qualified personnel for my child in the event that such treatment is deemed necessary or advisable for my child's health, safety and welfare. I release CPC and all medical providers from liability in acting on my behalf in this regard in rendering such medical treatment.

Release of Liability

I understand that participation in CPC activities is a privilege. In consideration of that privilege, I am signing this Release of Liability form on behalf of myself and/or my minor child who is participating in CPC activities. I understand that by partaking in CPC activities, my child and/or I may participate in any number of activities, some of which include, but are not limited to, recreational activities and games. I understand that there are certain risks, whether such risks are known or unknown to me at this time. I further release CPC, including its directors, volunteers, employees and agents, from any claim that I, or my child, may have against them as a result of physical injury or illness incurred during participation in CPC activities. In consideration of your accepting me or my child for participation in the above named program, activity or sport, I hereby, for myself, my heirs, executor and administrators, waive and release any and all rights and claims for damages that I may have against the above named organization and its agents, employees, representatives, successors and assigns for any and all injuries suffered by myself or my child that arise out of the above named program, activity or sport sponsored by the above named organization.

Current Medications: (Medications must be sent with participant in their original containers.)
Medication name For Dosage

Health Ins Co: _____ Group Number: _____
Phone number (____) _____ Primary card holder _____
SS# of insured _____

Primary Doctor: _____ Phone (____) _____
Note: I understand that my personal insurance is primary.

Parent or Guardian Signature

Date