

Ridge Point Community Church  
**Liability Release and Parental Consent  
for Medical Treatment of Minor Form  
to be used as needed by RPCC in 2010**

<b>Office Use Only</b>
Family Last Name: _____
Date Received: _____
Received by (Dept): _____

**Name/Birthdate(s) of Participant(s)**  
\*If more than 1 child in family, please list all in K-12<sup>th</sup>

**Parent(s)/Guardian(s) Names**

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Address: \_\_\_\_\_ Best Contact Phone #(s): \_\_\_\_\_

**RELEASE OF LIABILITY**

The Participant, their parents, guardians, heirs, assigns and representatives hereby release Ridge Point Community Church, its staff members, volunteers, agents and representatives of any and all liability for any loss, injury, or property damage which may be the result of any aspect of any church organized event, retreat, mission trip or excursion the Participant may participate in.

The Participant and the Participant's Parent(s) and/or Guardian(s) understand, acknowledge and accept that:

- There may be inherent risks, both known and unknown, in travel and in activities the participant will engage in that may result in an injury, serious injury and/or death.
- **Participants are not covered under any policy of insurance held by Ridge Point Community Church.**
- Participants must provide any and all insurance coverage for themselves, including, but not limited to health, life and liability insurance.
- Photos and videos may be taken of The Participant and may be used in any Ridge Point publications, or in some cases, partnering organizations affiliated with the event. Publication of these photos and videos may be done electronically via the internet and that after publication, the church will be unable to prevent persons from gaining access, copying photos and videos, and subsequently using, altering, or republishing it without consent.
- Waive any claim for damages against the church from unconsented use, alteration or republication of photographs or videos that may include The Participant.

**PARENTAL CONSENT OF MEDICAL FOR MEDICAL TREATMENT OF MINOR**

The Participant and the Participant's Parent(s) and/or Guardian(s) understand, acknowledge and accept that:

- They have temporarily entrusted the child to the care of Ridge Point Community Church and its adult staff members and/or volunteers. If after reasonable attempts to contact the parent(s) or guardian(s) are unsuccessful, Ridge Point Community Church and the adult staff members or volunteers are authorized by the parent(s) or guardian(s) to:
  - Consent to any x-ray examination, anesthetic, medical and/or surgical diagnosis and/or treatment, hospital care, and/or dental care for the child which is recommended by a licensed medical care provider and which will be performed by a licensed medical care provider, licensed within the state or country where the services are to be performed. Authorization is given to provide authority and power to designated RPCC adult staff member(s) and/or volunteer(s) to treat your child when advised by a licensed medical care provider and when the child's parents are unavailable to give consent.
  - Authorize any hospital which has provided treatment to the child to return physical custody of the child to designated RPCC adult staff member(s) and/or volunteer(s) when treatment is completed.
  - The parent(s) or guardian(s) agree to fully pay for any and all costs of medical or dental care provided to the minor and consented to by Ridge Point Community Church and/or its adult staff member(s) and/or volunteer(s).

I have read, understand and accept the terms above. This authorization shall remain in effect until December 31 of each calendar year, unless revoked in writing by parent or guardian and received by a RPCC staff member.

\_\_\_\_\_  
Participant Name & Signature

Dated: \_\_\_\_\_

\_\_\_\_\_  
Parent or Guardian Name & Signature (if participant under age 18)

Dated: \_\_\_\_\_

\_\_\_\_\_  
Parent or Guardian Name & Signature (if participant under age 18)

Dated: \_\_\_\_\_

**Medical Information \* Please attach additional sheet of information as necessary \***  
**It is the responsibility of the Participant/Parent/Guardian to inform RPCC of changes to this information.**

**Insurance Information:**

Insurance Company: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Plan Number: \_\_\_\_\_  
Insurance Co. Address/Phone: \_\_\_\_\_  
Employer Name/Address/Phone: \_\_\_\_\_

**Doctor Information:**

Doctor Name: \_\_\_\_\_ Office Name: \_\_\_\_\_  
Office Address/Phone: \_\_\_\_\_  
Family members under care of this Doctor: \_\_\_\_\_

**Doctor Information:**

Doctor Name: \_\_\_\_\_ Office Name: \_\_\_\_\_  
Office Address/Phone: \_\_\_\_\_  
Family members under care of this Doctor: \_\_\_\_\_

**Reminder: Emergency Phone, Parent(s)/Guardian(s) Name/Address on top of Page 1.**

**Child Specific Medical Information:**

Child Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Special Medical Conditions (ex. Allergies, Diabetes, Asthma, etc): \_\_\_\_\_  
Medications currently using & instructions: \_\_\_\_\_

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