



WOODRIDGE BAPTIST CHURCH 2020 LIABILITY RELEASE FORM

Activity: _____

In consideration for being accepted by Woodridge Baptist Church for participation in any and all Activities, we (I), being 21 years of age or older, do for ourselves (myself) and for and on behalf of my child (participant) hereby release, forever discharge and agree to hold harmless **Woodridge Baptist Church** and the directors thereof from any and all liability, claims or demands for personal injury, sickness or death, as well as property damage and expenses, of any nature whatsoever which may be incurred by the undersigned and the child – participant while said child is participating in the above described activity.

Furthermore, we (I) as parent/legal guardian hereby assume all risk of personal injury, sickness, death, damage and expense as a result of participation in recreation and work activities involved therein.

Further, authorization and permission is hereby given to said church to furnish any necessary transportation, food and lodging for this activity at my expense.

The undersigned further hereby agrees to hold harmless and indemnify said church, its directors, employees and agents, for any liability sustained by said church as the result of the negligent, willful or intentional acts of said participant, including expenses incurred attendant thereto.

We (I) are the parent(s) or legal guardian(s) of this participant, and hereby grant our (my) permission to take said participant to a doctor or hospital and hereby authorize medical treatment, including but in limitation to emergency surgery or medical treatment, and assume the responsibility of all medical bills, if any.

Further, should it be necessary for the participant to return home due to medical reasons, disciplinary action, or otherwise, we (I) hereby assume all responsibility.

Participant's Name: _____

Hospital Insurance? (*Circle One*) Yes No Policy No. _____

Insurance Company: _____

Alternate Emergency Contacts w/Phone Numbers:

Name: _____ Relationship: _____ Phone No. _____

Name: _____ Relationship: _____ Phone No. _____

Allergies: _____

Special Physical Needs: _____

Medications Required for Health Necessity/Safety of Others: _____

Do you have the medications with you? _____ Where? _____

Signature: _____ Date: _____

Witness Signature: _____ Date: _____