Carmel Baptist Church
Release & Consent Agreement for Youth
Valid September 1, 2019 — August 30, 2020

We, the undersigned participant and parent and/or legal guardian, for ourselves, our heirs, executors and administrators, HEREBY RELEASE, WAIVE AND FOREVER DISCHARGE any and all claims for damages which the participant may have or which may hereafter accrue to the participant against CARMEL BAPTIST CHURCH, its members, officers, agents, representatives, successors and/or assigns, individually and collectively, for any and all loss, injury or damage which may be sustained and suffered by the participant in connection with his/her association with CARMEL BAPTIST CHURCH or arising out of traveling with, participating in or returning from any activity sponsored by CARMEL BAPTIST CHURCH (the "Church Activity").

We do hereby authorize any of the designated adults monitoring the Church Activity on behalf of CARMEL BAPTIST CHURCH to contact a physician for the participant and/or to dispense over-the-counter medications to the participant, if necessary. We also authorize such designated adults to consent to medical care necessary for the participant's well-being, including x-ray examination, anesthetic, medical or surgical procedures or treatments and/or hospital care as advised by the participant's physician and/or surgeons in the event that a parent/legal guardian or emergency contact cannot be reached. We further authorize such designated adults to share the Medical History Form attached to this Release and Consent Agreement with CARMEL BAPTIST CHURCH employees, agents and members, as necessary, and to medical personnel for purposes of treating the participant.

We hereby grant Carmel Baptist Church the absolute right and unrestricted permission to take photographs and/or video of the participant during a Church Activity and to use and distribute such photographs and/or video for purposes of marketing, publicizing activities of the church or for any other lawful purpose. Photographs or video of the participant may be used in printed publications, multimedia presentations, on websites or in any other distribution media.

WE HAVE READ AND VOLUNTARILY SIGNED THIS RELEASE AND CONSENT AGREEMENT AND FULLY UNDERSTAND THAT WE HAVE KNOWINGLY GIVEN UP LEGAL RIGHTS BY VOLUNTARILY SIGNING IT.

*Participants SS # _____

Participant's Name:

_____

(Please Print) Last First Middle

Address: _____

Street City/State/Zip

Parent Phone:_____ Student Phone:_____

In the event parents cannot be reached, please call: _____

Relationship: _____ Phone: _____

Insured Person's Name: _____ Insurance Company: _____

Policy Number:_____ Name of Physician: _____

Your child's social security number is OPTIONAL. If your child has to go to the hospital, the hospital will bill your insurance company if you have their social security number; if you don't have the social security number the hospital will bill you and you will submit the bill to your insurance company.

PLEASE COMPLETE THE STUDENT HEALTH AND MEDICAL FORM ATTACHED TO THIS DOCUMENT.

Participant's Signature: _____

Signature of Parent or Guardian: _____

Student Name:

Student Health and Medical Forms

Medical History – Medication Allergies

Student is allergic to Amoxicillin
Yes **No**

Student is allergic to Ibuprofen
Yes **No**

Student is allergic to Penicillin
Yes **No**

Student is allergic to Tylenol
Yes **No**

Student is allergic to another medication
Yes **No**
Explain:

Medical History - Allergy History

Student is allergic to insect stings
Yes **No**
Explain:

Student is allergic to Shellfish, Eggs, Milk, or Peanuts
Yes **No**
Explain:

Student is allergic to other foods
Yes **No**
Explain:

Student is allergic to Poison Ivy, Poison Oak, or Sumac
Yes **No**
Explain:

Medical History - Health History

Asthma
Yes **No**

Has your student been hospitalized in the last year?
Yes **No**

Blood Disorders
Yes **No**

Physical Disability (muscular/coordination)
Yes **No**

Blind / Legally Blind
Yes **No**

Celiac Disease
Yes **No**

Eczema
Yes **No**

Seizure Disorder
Yes **No**

(Previous) Back or Neck injury
Yes **No**

Other medical concerns
Yes **No**
Explain:

Medical History - Medications

* Students are responsible to take their own prescription medications

Please indicate if your student is currently taking any medication or will be taking medications during an event.
Yes **No**

If so, please describe: