

ALLIANCE FIRST FRIENDS CHURCH
PARENTAL CONSENT AND LIABILITY RELEASE

Name: _____ Age: _____ Birthdate: _____
Address: _____ City: _____ State: _____ Zip: _____
School: _____ Grade: _____ Phone: (____) _____
Parent(s) home phone: (____) _____ Parent(s) business phone: (____) _____

TO WHOM IT MAY CONCERN:

The undersigned does hereby give permission for our (my) child, _____, to attend and participate in MARCH FOR LIFE - WASHINGTON D.C. sponsored by Alliance First Friends Church on January 22-24, 2012.

Parent's Signature _____ Date _____

RELEASE OF ALL CLAIMS

We (I) do hereby release, forever discharge and agree to hold harmless Alliance First Friends Church and the directors thereof from any and all liability, claims or demand 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 that occur while said child is participating in any activities and trips.

Furthermore, we (I) on behalf of our (my) child-participant hereby assume all risk of personal injury, sickness, death, damage, and expense as a result of participation in recreation and work activities involved therein.

The undersigned further hereby agree 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.

Should it be necessary for our (my) child to return home due to medical reasons, disciplinary action, or otherwise, the undersigned shall assume all transportation costs for our (my) child-participant and one adult chaperone.

MEDICAL TREATMENT RELEASE

We (I) authorize an adult, in whose care the minor has been entrusted, to consent to any x-ray examination, anesthetic, medical, surgical, or dental diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis to treatment is rendered at the office of said physician or at said hospital.

The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

Medical Insurance	_____ Yes	_____ No
Insurance Company (s)	_____	Policy Numbers
	_____	_____
Physician:	_____	Phone (____) _____
Emergency Phone Number:	(____) _____	
	(____) _____	(____) _____

COMPLETE BY A NOTARY:	State of Ohio _____	County _____
_____	_____	_____
(Father, Legal Guardian)		(Mother, Legal Guardian)
Affirmed and subscribed in my presence		
This _____	day of _____	19 ____
Notary:	_____	
My commission expires _____		19 ____

Please list any medical allergies, medicines being taken, or special needs: