I, the undersigned parent or guardian, hereby consent to my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, who is \_\_\_\_\_ years of age, participating in the activities connected with trips to and from and the time at\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

from: Day \_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Year \_\_\_\_\_\_\_\_ thru: Day\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Year \_\_\_\_\_\_\_, an activity sponsored by **Journey Assembly of God, Inc**.

I certify that my child is able to participate in all activities scheduled for this event/trip. If my child has medical conditions which may be relevant to a physician in the event of an emergency, I have listed them below.

**I UNDERSTAND AND HEREBY AGREE TO ASSUME ALL OF THE RISKS WHICH MAY BE ENCOUNTERED DURING SAID ACTIVITIES, INCLUDING ACTIVITIES PRELIMINARY AND SUBSEQUENT THERETO.** I do hereby agree to hold **Journey Assembly of God** and their agents, volunteers and employees, harmless from any and all liability, actions, causes of actions, claims, expenses, and damages on account of injury to my child or property, even injury resulting in death, which I now have or which may arise in the future in connection with the activity or participation in any other associated activities.

I expressly agree that this release, waiver and indemnity agreement is intended to be broad and inclusive as permitted by the law of the State of Florida and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect. This release contains the entire agreement between the parties hereto, and the terms of this release are contractual and not a mere recital.

I further state that I HAVE CAREFULLY READ THE FOREGOING RELEASE AND KNOW THE CONTENTS THEREOF AND I SIGN THIS RELEASE AS MY OWN FREE ACT. This is a legally binding agreement which I have read and understand.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian

**CHILD/STUDENT PARTICIPANT INFORMATION** - *(To be completed by parent or authorized guardian)*

|  |  |
| --- | --- |
| Participant:  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone No: (\_\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_  Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ | Emergency Contact Information:  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Daytime Phone No: (\_\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_  Evening Phone No: (\_\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_  Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**NOTE: IN CASE OF A MEDICAL EMERGENCY, CALL 911**

List any current allergies, illnesses, or medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any current physical restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last tetanus or booster shot: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I do not wish for my child to participate in the following activities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Hospital for Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_