

Name (Last, First) _____

Consent to Medical Care of Minor

CONSENT TO MEDICAL TREATMENT

(Date)

I, _____, the _____ (father) (mother), of _____, a minor child, whose birth date is _____, authorize medical treatment during the year **20__**, for the purpose of attempting to relieve any condition which may occur while my child participates in **ANY AND ALL** of the events or activities of Denton Bible Church Student Ministries.

I further authorize the performance of any procedure that is deemed advisable in attempting to relieve this condition or any related unhealthy condition that may be encountered during any necessary operation.

I also consent to the administration of anesthesia to be applied by or under the direction of an anesthesiologist and to the use of such anesthesia as deemed advisable.

The effect and nature of the treatments of operations to be performed, and the possibility of complications and unforeseen consequences, have been explained to me. No warranty has been made as to the results to be obtained.

(Signature of parent or guardian)

(Printed name and relationship)



WAIVER AND RELEASE OF LIABILITY

This Waiver and Release of Liability (“Waiver”) is entered into on the _____ day of _____, 20____, by and between Denton Bible Church (the “Church”) and _____ [name of participant] (“Participant”).

Participant desires to participate in **ANY AND ALL** events or activities during the year **20__** on the Church’s premises or as part of an off-premise Church activity.

In consideration of being permitted to participate in the Activity, Participant agrees as follows:

I RELEASE, WAIVE ALL CLAIMS AGAINST, DISCHARGE AND COVENANT NOT TO SUE THE CHURCH, OR ANY OF THE CHURCH’S ELDERS AND EMPLOYEES, INCLUDING BUT NOT LIMITED TO PASTORS, STAFF AND OTHER EMPLOYEES, MEMBERS, REPRESENTATIVES, OR VOLUNTEERS (COLLECTIVELY REFERRED TO HEREIN AS “CHURCH REPRESENTATIVES”) WITH RESPECT TO MY PARTICIPATION, INCLUDING WITHOUT LIMITATION ATTENDANCE AT, OBSERVATION OF, OR BEING OTHERWISE INVOLVED IN THE ACTIVITY (“PARTICIPATION”), WHETHER MY CLAIM OR THE CLAIM OF ANYONE ON MY BEHALF IS BASED ON OR ARISES OUT OF PERSONAL INJURY, DEATH OR INJURY TO PROPERTY AND

WHETHER SUCH CLAIM IS CAUSED BY THE NEGLIGENCE OF THE CHURCH OR ANY OF THE CHURCH REPRESENTATIVES.

I ASSUME FULL RESPONSIBILITY FOR AND RISK OF BODILY INJURY, DEATH OR PROPERTY DAMAGE DUE TO THE NEGLIGENCE OF THE CHURCH OR ANY OF THE CHURCH REPRESENTATIVES WITH RESPECT TO MY PARTICIPATION IN THE ACTIVITY.

I agree to indemnify and hold the Church harmless from the claims of any third party arising as a result of my participation in the Activity.



I HAVE READ THIS WAIVER IN ITS ENTIRETY AND I UNDERSTAND THAT BY SIGNING THIS WAIVER I AM RELEASING ALL FUTURE CLAIMS I MAY HAVE AGAINST THE CHURCH AND ANY CHURCH REPRESENTATIVES WITH RESPECT TO MY PARTICIPATION IN THE ACTIVITY.

PARTICIPANT(s):

Signature(s):

Signature(s):

Printed Name(s):

PARENT OR GUARDIAN OF PARTICIPANT, ON BEHALF OF PARTICIPANT (if under 18):

Signature:

Printed Name: _____,

on behalf of _____ [minor Participant's name]

_____ [minor Participant's name]

_____ [minor Participant's name]

_____ [minor Participant's name]

_____ [minor Participant's name]

_____ [minor Participant's name]

_____ [minor Participant's name]



MEDICAL RELEASE FORM

As the parent/legal guardian of:

Student Name(s): _____

I request that in my absence the above-named student(s) be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named student.

Date of birth(s): _____

Allergies: _____

Other Medical Conditions: _____

Physician: _____ Phone #: () - _____

Name of Parent/Guardian: _____

Street Address: _____ City: _____ State TX

Zip Code: _____ Phone # H: () - _____ Work #: () - _____

Person to notify if parent/guardian is unavailable: _____

Street Address: _____ City: _____ State: _____

Zip Code: _____ Phone # H: () - _____ Work #: () - _____

Medical and/or Hospital Insurance Co | () - _____
Phone #:

Policy Holder | _____
Policy Number

Signature of Parent /Guardian: _____ Date: _____