

RELEASE FORM

for the activities of

Student Ministries at Avalon Missionary Church

My child has my permission to participate in the youth activities, programs, and ministries of Avalon Missionary Church (collectively "Activities"). I recognize that in any youth Activities, especially those which include traveling, there is the risk of personal injury to my child and damage to or the destruction of personal property. I also understand that the insurance which the church carries is primarily intended to cover medical expenses not covered by my own health insurance up to the limit specified in the church's policy.

In the event of a medical emergency when I, the parent or legal guardian, cannot be reached, I hereby authorize the youth leader, or designated adult counselor, to secure the necessary medical or dental treatment at any hospital, clinic, or doctor's office.

Further, in consideration of my child's participation in the Activities, I promise to indemnify, defend, and hold harmless Avalon Missionary Church, its agents, employees, volunteers, and any other representatives (collectively referred to hereinafter as the "Church") from and against any and all claims, actions and causes of action arising out of or in any manner relating to any personal injury suffered by my child or the damage or destruction of personal property related directly or indirectly to the Activities or transportation to and from the Activities ("Claims"), whether such Claims arise out of the negligence of the Church or otherwise.

Name of Student: _____ Date: _____

Signatures: _____ Relationship: _____

_____ Relationship: _____

Birthdate: _____ Year youth should graduate High School: _____

Guest of: _____ (if youth is a visitor)

Home Address: _____

City: _____ ZIP: _____ Home Phone Number: _____

Parent/Guardian Name: _____ Work Phone #: _____ Cell Phone #: _____

Parent/Guardian Name: _____ Work Phone #: _____ Cell Phone #: _____

Emergency Contact Person: _____ Relationship to Youth: _____

Emergency Contact Phone Number: _____

Health Insurance Company: _____

Policy and/or Group #: _____

Physician's Name: _____ Phone #: _____

Dentist's Name: _____ Phone #: _____

Orthodontist's Name: _____ Phone #: _____

Optometrist's Name: _____ Phone #: _____

Allergies: _____

Physical Limitations: _____

Regular Medications: _____

Other Health Considerations: _____

Please attach a current copy of any applicable insurance Cards. Thank you.