

Alliance Friends Church Youth  
Parental Consent and Liability

Student Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
School: \_\_\_\_\_ Parent/Guardian Phone: \_\_\_\_\_

**TO WHOM IT MAY CONCERN:**

The undersigned does hereby give permission for our (my) child, \_\_\_\_\_, to attend and participate in any sponsored events and services with Alliance Friends Church-Generate in 2024

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

**RELEASE OF ALL CLAIMS**

We (I) do hereby release forever discharge and agree to hold harmless Alliance 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 events 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 participating 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 a result of negligent, willful or intentional acts of said participant, including expenses uncured attended there to.

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 cost for our (my) child participant and one (1) adult chaperone.

**MEDICAL TREATMENT RELEASE**

We (I) authorize any 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 provision 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 agrees 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 or NO	
Insurance Company(s)	Policy Numbers
_____	_____
_____	_____
Physician: _____	Phone: _____
Emergency Phone Number(s)	
_____	Relation: _____
_____	Relation: _____

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

\_\_\_\_\_