Christ's American Baptist Church
Permission/Medical/Photo Release Form

I give permission for our (my) child,_____, to attend and participate in all events (including
(Name of child)
overnight events and transportation by bus, van, car, etc.) of the CABC PULSE Youth Ministries from:

Aug 1, 2023 to September 1, 2024

We (I) hereby release Christ's American Baptist Church, its staff and volunteers, from responsibility and liability for any injury or illness that our (my) child may sustain during any C.A.B.C. Youth Ministries event.

We (I) authorize an adult leader, as an agent for us (me), to consent to any X-ray examination; medical, dental or surgical diagnosis; treatment; and hospital care advised and supervised by a physician, surgeon or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered, either at a doctor's office, any hospital, or at any clinic. I expect to be contacted as soon as possible.

We (I) shall be liable and agree to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization. Should it be necessary for our (my) child to return home due to medical reasons or otherwise, we (I) shall assume all transportation costs.

We (I) give permission for my child to be photographed by Christ's American Baptist Church, its staff and volunteers, during any C.A.B.C. Youth Ministries event and give permission for those pictures to be published in any official way deemed appropriate by the C.A.B.C. leadership.
Opt-Out of Photo Release must be made in writing to C.A.B.C.

We (I) will notify Christ's American Baptist Church of any changes in our (my) child's medical information.

_____ _____ _____
(Signature of parent or legal guardian) **(Print name of parent or legal guardian)** **(Date)**

_____ _____ _____
(Signature of parent or legal guardian) **(Print name of parent or legal guardian)** **(Date)**

EMERGENCY CONTACT(S)

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

MEDICAL INFORMATION

Allergies: _____ Medications: _____

Physical Handicaps or Limitations: _____

Medical Insurance:
Provider: **Policy #:** **Members Name:**

Please Fill Out Completely