



## RELEASE AND CONSENT FORM - Adults

6-9-16

I hereby, for myself, my heirs, executors, and administrators, waive and forever discharge any and all right and claims for damages which I may have or which may hereafter accrue to me against CARMEL BAPTIST CHURCH, their members, respective officers, agents, representatives, successors, and/or assigns, individually or collectively for any and all damages and liabilities which may be sustained and suffered by me in connection with my association with/or arising out of my traveling with, participation in, and returning from any activity sponsored by CARMEL BAPTIST CHURCH.

The undersigned further agrees that he/she will not institute any action or suit at law or in equity against Carmel Baptist Church, its directors, officers, members, administrators, employees, members, team captain or team coordinators and/or team members at any time, and will not institute, prosecute, or in any way aid in the damages, loss, loss of services, expenses or compensation for or on account of any alleged damage, loss, injury, health problem, disease, or illness to any person or property, or both, whether developed or undeveloped, resulting from or to result from known, unknown, past, present or future by the said participant's participation in mission projects sponsored by CARMEL BAPTIST CHURCH.

The person and others whose signature are attached below do hereby consent to any and all medical and surgical treatments including anesthesia and operations which may be deemed advisable by his or her physician and surgeons. I (we) understand that in the event medical treatment is required, every effort will be made to contact me. However, if I cannot be reached, I give my permission to the staff or sponsor to secure the services of a licensed physician to provide necessary care, including anesthesia, for my child's well-being. I (we) also fully assume the responsibility for all medical bills and associated costs.

In witness of our consent and agreement to the matters stated in the preceding sentences, we have subscribed our signatures below.

DATE: \_\_\_\_\_ TRIP NAME: \_\_\_\_\_ DATES OF TRIP: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ PASSPORT NUMBER: \_\_\_\_\_

PARTICIPANT'S NAME: \_\_\_\_\_  
Last Middle First

ADDRESS: \_\_\_\_\_  
Street City State Zip

YOUR EMAIL: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

NAME OF EMERGENCY CONTACT: \_\_\_\_\_ Relationship \_\_\_\_\_

Address of Emergency Contact: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email \_\_\_\_\_

Work Phone: \_\_\_\_\_ Best way to reach this person: \_\_\_\_\_

### SECONDARY INSURANCE INFORMATION:

Carmel Baptist Church will secure accident and injury insurance for each volunteer during the mission trip. The following information is needed to secure this insurance:

Beneficiary Full Name \_\_\_\_\_ Relationship to Beneficiary \_\_\_\_\_

### MEDICAL INFORMATION:

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

Do you take any medication on a regular basis? \_\_\_Yes \_\_\_ No

If yes, please describe \_\_\_\_\_  
(If you are on medication during this trip, please notify the adults in charge)

Is sponsor authorized to approve medical treatment? \_\_\_ Yes \_\_\_ No

Is participant covered by personal/family medical insurance? \_\_\_ Yes \_\_\_ No

If yes, Name of Insurer: \_\_\_\_\_ Policy or Group Number \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date