Parent/Guardian Waiver & Release for Minor Participation

Cardboard City – November 17-18, 2017

Please print in ink:

Effective Dates: November 17, 2017 to November 18, 2017

Minor's Name (last, first,middle)____

Age:____Birthdate:___/___/___ Male____Female_____Email:____

Address:____City:________________State:_______ZIP:__________

Mother's Name:__________________________________Home: (____)____________Cell: (____)___________

Father's Name:___________________________________Home: (____)____________Cell: (____)___________

Emergency Contact:______________________________ Home:(____)____________Cell: (____)____________

Medical Insurance Company:______________________________Policy #:______________________________

Does your child have allergies to:
___Pollens ___Medications ___Food ___Insect Bites (if yes to any please specify)__________________________

Does your child suffer from or has ever experienced, or is being treated currently for any of the following:
___Asthma ___Diabetes ___Heart Trouble ___Epilepsy/Seizure /Disorder/ Date of last tetanus shot _____/_____

The undersigned ________________________ (name of parent/guardian), the parent and natural or legal guardian of the above minor hereby represents that he or she is, in fact, acting as such capacity and AGREES TO DEFEND, HOLD HARMLESS, AND INDEMNIFY FAMILY PROMISE OF JACKSONVILLE, CROSSROAD CHURCH, AND ANY OF ITS OFFICERS, DIRECTORS, TRUSTEES, AGENTS, SERVANTS OR EMPLOYEES (COLLECTIVELY "FAMILY PROMISE" AND "CRC") FROM ALL LIABILITY, LOSS, OR HARM THAT MAY OCCUR BY REASON OF THE MINOR'S PARTICIPATION IN THE CARDBOARD CITY EVENT. BY MY SIGNATURE BELOW, I ACKNOWLEDGE AND AGREE TO THE ABOVE WAIVER AND RELEASE AND TO PERMISSION FOR MEDICAL ATTENTION SET FORTH BELOW.

I further give Family Promise permission to seek whatever medical attention is deemed necessary, and release Family Promise of Jacksonville of any liability against personal losses of the above minor. In the event that the above minor is injured and requires the attention of a doctor, I consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is required from a physician and/or hospital personnel designated by Family Promise of Jacksonville, I agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. I also acknowledge that I will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider. Further, I affirm that the health insurance information provided above is accurate at this date and will, to the best of my knowledge, still be in force for the above minor.

Parent Name:_______________________Parent Signature:______________________Date:_____

Parent Name:_______________________Parent Signature:______________________Date:_____
Parent Telephone Number: ____

Any questions, please contact Beth Mixson at (904) 537-3645 or bethmixson@familypromisejax.org
For more information, visit www.familypromisejax.org