Parent/Guardian Waiver & Release for Minor Participation

Cardboard City – November 15-16, 2024,

Please print in ink: *Effective Dates*: November 15-16, 2024,

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

_____

Age:____Birthdate:___/___/___ Male____Female_____Email:_____

Address:_____City:_____State:_____ZIP:_____

Parent/ Guardian Name:_____Home: _____Cell: _____

Parent/ Guardian Name:_____Home: _____Cell: _____

Emergency Contact:_____ Home:(____)_____Cell: (____)_____

Medical Insurance Company:_____ Name of Insured:_____

Policy #:_____ Group #_____

Does the minor have allergies to:
___Pollens ___Medications ___Food ___Insect Bites (if yes to any please specify)_____

Does the minor 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 custodial parent or legal guardian of the above minor hereby represents that he or she is acting in such capacity and AGREES TO DEFEND, HOLD HARMLESS, AND INDEMNIFY FAMILY PROMISE OF JACKSONVILLE, LAKEWOOD CHURCH, AND ANY OF ITS OFFICERS, DIRECTORS, TRUSTEES, AGENTS, EMPLOYEES, OR VOLUNTEERS (HEREAFTER COLLECTIVELY "FAMILY PROMISE" AND "LAKEWOOD METHODIST CHURCH") 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 GIVE PERMISSION FOR NECESSARY MEDICAL ATTENTION AS SET FORTH BELOW.

I give Family Promise permission to seek whatever medical attention is deemed necessary, and release Family Promise of Jacksonville from any liability arising from personal losses related to the above minor. In the event that the above minor is injured and requires the attention of a medical professional, I consent to any reasonable medical treatment as deemed necessary by a licensed physician or other appropriate licensed medical professional. In the event treatment is required by a medical professional and/or hospital, and consent is provided by authorized Family Promise personnel, I agree to hold Family Promise personnel free 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 not reimbursed by the health insurance provider. Further, I affirm that the health insurance information provided above is accurate as of this date and will be updated prior to the event, if necessary.

Parent/Guardian Name:_____

Parent Signature_____ Date:_____

Telephone Number:_____

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