

Upper Room Junior High Medical & Liability Consent Form

This Consent Form covers all URJH events from September 2011 through August 2012
(Wednesday nights, NOF's, retreats, and trips)

This Consent Form seeks permission, indicated by your signature(s) below, to seek whatever medical attention is deemed necessary in the event of an injury to your child during an URJH event. It also requests that you agree to release Upper Room and all of its employees, agents, representatives, and volunteers from any claims, demands, injuries, damages, actions or causes of action, and liabilities arising out of or connected with URJH events, or any act or omission, including negligence by URJH employees, agents, representatives, or volunteers. Your agreement to so release URJH is indicated by your signature below.

I/We understand that there are inherent risks involved in any student event, including URJH events, and I/we hereby release Upper Room and all of its employees, agents, representatives, and volunteers from any claims, demands, injuries, damages, actions or causes of action, and liabilities arising out of or connected with URJH events, or any act or omission, including negligence by URJH employees, agents, representatives, or volunteers.

I/We, the undersigned, are the parents, the parents having legal custody, or the legal guardians of _____, a minor, and have given our consent for him/her to attend URJH events (held between September 2011 - August 2012), being organized by Upper Room. In the event that he or she is injured while attending any event and requires the attention of a doctor, I/we consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is required which a physician and/or hospital personnel refuses to administer without my/our consent, I/we hereby authorize the UR staff, or another adult leader designated by them, to give consent for us, and I/we agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent so long as the treatment is administered by or under the supervision of a licensed physician. I/We also acknowledge that we will be ultimately responsible for the costs of any medical care should the cost of that medical care not be reimbursed by the health insurance provider. Further, I/we affirm that the health insurance information provided below is accurate at this date and will, to the best of my knowledge, still be in force for the student named above at the time of the event.

Please fill out the following information and sign below:

Student's Name: _____ Date of Birth: _____

Address: _____
Street City Zip Code

Insurance Provider: _____ Policy #: _____

Known allergies & current medications: _____

Parent(s)/Guardian(s) (if participant is under 18)

Print Name Cell Phone Number Signature

Print Name Cell Phone Number Signature

Additional information for us to know: _____