**Permission and Acknowledgement of Risk and Waiver (Medical Release) Form**

PIEDMONT COMMUNITY CHURCH STUDENT MINISTRIES

400 Highland Avenue, Piedmont, CA 94611 510-547-5700, ext.110

This form serves as consent of permission for participation in PCC Student ministries events and activities

ACTIVITY: Mexico Mission 2018

DATE: October 27-30, 2017

Participant:(Last)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(First)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:(\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_\_/\_\_\_

Home Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Age: \_\_\_\_\_\_\_\_

Parent or Guardian Name: 1)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: (\_\_\_\_)\_\_\_\_ -\_\_\_-\_\_\_\_\_\_ Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian Name: 2)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: (\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_\_

Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_

Person to contact in case of emergency while in Mexico:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number of above: (\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_\_

**Please fill out below completely: This information is important to maintain participants safety**

List any current allergies to medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If peanut allergy, please explain the severity and what the reaction is, for example - is an epi pen necessary?*

List any allergies to food or dietary restrictions/needs:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list only medical dietary restrictions. It’s not possible for us to meet all choices.

List any current Medical Conditions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is any assistance needed for disabilities?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Attach list if necessary

Date of Tetanus Booster (**Must be current to attend**)\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_

Health Insurance Carrier\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*As the Participant or Guardian of the Participant, I agree to the following:*

 I hereby give my permission for my child to attend and participate in the activity listed above, and I authorize

the trip sponsor to furnish any necessary transportation, food and lodging for the participant.

 I agree to waive any and all rights and claims for damages that I or my spouse may have against Piedmont

Community Church, the trip sponsor, and its agents, employees, and representatives for any and all injury,

damage, or loss sustained by the participants arising directly or indirectly from the trip.

 I further agree that, in the event that I, my spouse, the participant or another child in my care should make claim

against the trip sponsor for damage, injury, liability, costs of suit, judgments, or loss arising directly or indirectly

out of the trip, I personally indemnify, defend and hold harmless the trip sponsor and its agents, employees, and

representatives against any and all such injury, damage or loss.

 I authorize the trip sponsor or their representative to obtain any medical treatment for the participant that should

appear to be necessary during the trip, and I will be responsible for the payment of expenses relating to such illness

or injury; furthermore, should it be necessary for the participant to return home due to medical reasons, disciplinary

action or otherwise, I hereby assume all transportation costs;

 I affirm that I have the right to authorize and agree to the foregoing. I have carefully read and understand this agreement

and have willingly placed my signature below as evidence of my acceptance of all the conditions contained herein.

**Signature of Participant**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_

\*\*\*\*\*\*\*\*Parent or Guardian must sign if above is under 18 years of age\*\*\*\*\*\*\*\*\*\*

**Parent/Guardian Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_