# The New Testament Baptist Church, Claridon, Ohio

Assumption of risk and medical treatment authorization form for adult, youth, and other participant in voluntary field trip

Date:_____ Time of departure: _____

Full Name of Participant (s):

_____

Sponsors in Charge:_____

Type of transportation: _____

___ I will use transportation provided by New Testament Baptist Church (check if using)

**HEALTH OR SPECIAL NEEDS:**

**___ I have no special health needs the sponsors should be aware of, and no medication is required for this trip**

**___ I have a special need and instructions are attached. Number of pages attached:____**

**_____**

**Describe special need on line above**

**___ Other**

In the event of illness or injury, I do hereby consent to whatever x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care considered necessary in the best judgment of the attending physician, surgeon, or dentist and performed under the supervision of a member of the medical staff of the hospital or facility furnishing medical or dental services. It is understood that the resulting expenses will be the responsibility of the student/participant. Furthermore, I fully understand that participants are to abide by all rules and regulations governing conduct during the trip.

I understand and agree to waive all claims against The New Testament Baptist Church and its sponsors, holding them harmless from any and all liability or claims, demands, losses, causes of action, suits or judgments of any kind whatsoever that I, my heirs, executors, administrators or assignees may have against The New Testament Baptist Church and its sponsors due to death, bodily injury, personal injury, or illness, or because of any loss to property that may arise out of or in any way connected with the above-described excursion/field trip.

_____

Printed name of parent/guardian Signature of parent/guardian DATE

Home Phone_____Work phone_____ cell_____

_____

Family Medical Insurance Carrier

_____

Phone and address of Insurance Carrier

_____

Policy Number