FamilyPromise
of Shenandoah County

Parent/Guardian Waiver & Release for Minor Participation
Cardboard City – September 6-7, 2019

Please print in ink:

Effective Dates: September 6-7, 2019

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, please specify): _____

Does your child suffer from, 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/she is, in fact, acting as such capacity and AGREES TO DEFEND, HOLD HARMLESS, AND INDEMNIFY FAMILY PROMISE OF SHENANDOAH COUNTY, ANTIOCH CHURCH OF THE BRETHREN, AND ANY OF ITS OFFICERS, DIRECTORS, TRUSTEES, AGENTS, SERVANTS OR EMPLOYEES (COLLECTIVELY "FPSC" AND "ACOB") 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 FPSC permission to seek whatever medial attention is deemed necessary, and release FPSC 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 FPSC, 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 my 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: _____

Any questions, please contact Diane Pence at 540-459-4599 or shenfamilypromise@gmail.com