MEADOWBROOK

WAIVER AND INDEMNITY AGREEMENT

Name of Participant _____

In consideration of your accepting me/my child for participation in the activities, events, and trips for the Meadowbrook Youth Group, I hearby, for myself, my heirs, executors, and administrators, waive and release any and all rights and claims for damages that I may have against Meadowbrook Church of Christ of Jackson, and its officers, elders, ministers, leaders, agents, servants, employees, and all private persons or organizations volunteering services without charge to supervise or chaperone me/my child while on any trips or activities from any claim or liability whatsoever, including, but not limited to, personal injury, property damage, court costs, attorneys' fees and interest, however caused, by myself/my child as a result of my/my child participating in the trip or activity.

I do further agree that the Church, its officers, elders, ministers, leaders, supervisors, agents, servants, employees, and all private persons or organizations volunteering services without charge to supervise or chaperone reserve the right to terminate my/my child's participation for failure to behave and act in accordance with the Church's regulations on conduct, for failure to follow the instructions or directions of the supervisor(s) and/or chaperones, or for any of my/my child's acts of conduct deemed by said board, its officers, agents and/or employees, to be detrimental to or incompatible with the interest, harmony, comfort or welfare of any event, trip, or activity as a whole. If the participation of the above Participant is terminated, only the funds not actually used will be refunded, and I/my child will be sent home at my expense.

LIMITED POWER OF ATTORNEY

If I cannot be immediately contacted, I grant full power of attorney to the official representative or chaperone in the event of accident or illness of the above Participant at any time from the commencement to the termination of the trip, to do as follows:

1. To arrange for the transportation of the above Participant, whether by ambulance or otherwise, to a proper facility where emergency medical treatment would normally be administered, including, but not limited to, an emergency room of a hospital, a doctor's office, or a medical clinic, and
2. To sign any releases as may be required in order to obtain any medical or surgical treatment as is required in the judgment of medical authorities at the facility.
3. To do and perform every act necessary and proper to be done in the exercise of any of the foregoing powers as fully as I might or could do if personally able, with full power of substitution and revocation hereby ratifying and confining all that my said attorney(s) shall lawfully do or cause to be done by virtue hereof.
4. I further aver that I have disclosed all known medical conditions, allergies, hypersensitivity's, illnesses (chronic or otherwise) and other medical information to my said attorney(s) pertaining to above Participant.

Participant _____ Date _____
(Provide proof of age if not a minor)

Parent/Legal Guardian _____ Date _____
(Required for all Participants)

Parent/Legal Guardian _____ Date _____

Notary Signature and Expiration: _____

Medical Information

Name of Participant_____Sex_____Birthday_____Age_____

Parent/Guardian Name_____

Home address_____

Home phone_____Cell phone_____Other phone_____

If not available in an emergency, notify:

Name_____Phone_____

List Allergies: (Drugs, insect stings, poison ivy, hay fever, other)

_____
_____
_____

Do/Does you/your child have any medical or health problems, any chronic or recurring illness or illnesses that would have an effect on your/your child's participation in any trip, activity or sport?
Yes_____ No_____

If yes, please describe_____
_____

Date of last tetanus shot_____

Medications you/your child take(s) regularly_____

Instructions for this medication_____
_____

☐ **I/My child may self-administer** ☐ **Please adult administer**

Please check the over-the-counter medications that may be administered to your child:

Tylenol_____, Advil_____, Tums_____, Emetrol_____, Benedryl_____, Immodium_____, Cortisone Cream_____, Triple Antibiotic Ointment_____, Cough Drops_____, Sudafed_____, Other (describe)_____
_____

State the name, medical specialty and phone number of the Participant's physician who should be consulted in the event of emergency or medical problems involving this Participant:

Physicians Name_____Medical Specialty_____

Phone _____

My/My child's medical/hospitalization insurance information:

Insurance Co._____ Policy Holder_____

Policy Number_____Ins. Co. phone number_____