MEDICAL RELEASE WAIVER

Families may put all names on one form with BOTH parents signing.

Full Name: _____ DOB: _____

_____

Address: _____

Drug Allergies: _____

Emergency Contact Information:

Name _____ Phone_____ Relationship _____

In being allowed to participate in the Locust Springs Christian Retreat Center (LSCRC) Camp Program and activities associated with its program and location, I assume full responsibility for my actions.

I release LSCRC, First Church of God (Greeneville, TN), its staff, trustees, employees, volunteers, and agents from liability, loss, injury or damage to my property or myself.

Nothing contained herein shall excuse LSCRC, its staff, trustees, employees, volunteers or agents from responsibility to act with reasonable care for the safety of my property or myself.

I hereby release LSCRC, First Church of God (Greeneville, TN), its staff, trustees, employees, volunteers, agents or sponsors of this activity from responsibility and liability for any injury or illness that I may sustain during this activity. I agree to accept full responsibility for payment of any medical cost which may arise as a result of the trip to LSCRC.

In the event of an emergency, I hereby authorize an adult leader of this activity (affiliated with LSCRC or my group) as an agent of me, to consent on my behalf to medical treatment. In this regard I consent to allow said adult to authorize medical, dental, or surgical diagnosis; X-ray examination; treatment including surgery, and hospital care for me if needed and if advised and supervised by a licensed physician, surgeon or dentist.

Initial _____

Signature: _____ Date _____

Signature of Parent of Legal Guardian: _____
(*If under 18 yrs of age)*