

## MEDICAL WAIVER FORM

DATE OF INCIDENT: \_\_\_\_\_

I, THE UNDERSIGNED, DO HEREBY REFUSE MEDICAL ATTENTION AND/OR TRANSPORTATION TO A MEDICAL FACILITY. I ALSO RELEASE (CHURCH NAME) OF THE (STATE OR COMMONWEALTH THAT YOU LIVE IN), LOCATED IN THE (EX: COUNTY OR TOWN YOU LIVE IN), AND THE RESPONDING SAFETY OFFICERS / SECURITY TEAM / INDIVIDUALS FROM ANY AND ALL LIABILITY CONCERNING THE REFUSAL OF MEDICAL TREATMENT.

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SIGNATURE OF AIDED

WITNESSES

NAME AND POSITION IN CHURCH

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NAME AND POSITION IN CHURCH

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