

**Medical/Media Release for Sports Camp**

This release will be in effect from **June 2, 2025, to June 6, 2025**

**To Whom It May Concern:**

In the unlikely event that medical treatment is required, I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ as a parent and/or guardian of the child(ren) named below, **after a reasonable effort has been made to reach me,** grant permission to a representative of Cedar Valley Baptist Church to secure the services of a licensed physician. I do herewith authorize the treatment of the child(ren) named below if in the opinion of the attending physician, delay may endanger his/her life, cause disfigurement, physical impairment or undue discomfort.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, do release, acquit, discharge, and hold harmless: Cedar Valley Baptist Church, and its representatives from any and all damages or liabilities arising out of the treatment of any sickness or accident incurred by my child.

My signature serves to indicate my willingness: to take full financial responsibility for any and all medical services rendered for any of the below named child participant(s); for my insurance company to be billed for any and all medical fees and services should they be needed; and to release Cedar Valley Baptist Church and its employees/volunteers from this liability.

I also understand that as a participant, my child/student may be photographed or videotaped during Cedar Valley Baptist Church sponsored activities and I authorize these photos/videos to be used in promotional materials and/or the church website. (We will not use their names just their images.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (parent/guardian) Date

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group or ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- |
| 1.Child’s Name | 2.Child’s Name | 3.Child’s Name |
| Birthdate: Male/Female | Birthdate: Male/Female | Birthdate: Male/Female |
| List any current allergies, illnesses, physical conditions, dietary needs, or medications (attached another sheet if needed) | List any current allergies, illnesses, physical conditions, dietary needs, or medications (attached another sheet if needed) | List any current allergies, illnesses, physical conditions, dietary needs, or medications (attached another sheet if needed) |
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