

PLEASE PRINT LEGIBLY AND COMPLETE THIS FORM IN ITS ENTIRETY				
PARTICIPANT LAST NAME		FIRST NAME		MI
STREET ADDRESS			APT	
CITY		STATE	ZIP	
HOME PHONE	WORK PHONE	MOBILE PHONE		DATE OF BIRTH
EMERGENCY CONTACT		RELATIONSHIP		EMERGENCY PHONE
NAME OF PARENT/GUARDIAN IF PARTICIPANT IS UNDER AGE 18				

### Liability Release

I, \_\_\_\_\_ (Participant's name or parent/guardian if Participant is under age 18), release Times Square Church, its agents, assigns, employees and volunteer assistants from any and all liability whatsoever arising out of injury, sickness, or damage which may be sustained during the course of any activity with Times Square Church.

### Medical Release

I, \_\_\_\_\_ (Participant's name or parent/guardian if Participant is under age 18), consent for the director or properly appointed staff member or volunteer leader of Times Square Church to secure the administration of medical treatment or medication. I further consent to the performance of such treatment, anesthetic, and operations as, in the opinion of the attending physician, is deemed necessary.

List any medications or treatments that should not be given to Participant and reason why: \_\_\_\_\_

List medication Participant must take, the dosage, and time intervals. Please include doctor's note verifying the condition and treatment.

MEDICATION	DOSAGE	TIME INTERVALS	SPECIAL INSTRUCTIONS

List any foods Participant may not eat and reason why: \_\_\_\_\_

Does Participant have any physical, mental, or emotional condition? \_\_\_\_\_

### Insurance Information

I, \_\_\_\_\_ (Participant's name or parent/guardian if participant is under age 18), understand that it is my responsibility to provide for my or my child's accident and health coverage while participating in all activities with Times Square Church. I understand that my health insurance will be the primary insurance for any accident or medical claim, and that Times Square Church is under no obligation to pay for such care. I further understand that I am financially responsible for any treatment, prescriptions, or hospital care obtained for myself or my child. I consent to the release of this information as needed.

Is participant currently covered under a health insurance plan?  Yes  No *If yes, please complete below:*

NAME OF PRIMARY PERSON INSURED	INSURANCE COMPANY	POLICY NUMBER
--------------------------------	-------------------	---------------

SIGNATURE OF PARTICIPANT **X** \_\_\_\_\_ DATE \_\_\_\_\_  
 (or parent/guardian if participant is a minor)