



**CALVARY BAPTIST CHURCH**

**PERRY, FLORIDA**

**CONSENT & RELEASE FORM FROM LIABILITY AND INDEMNIFICATION**  
**FOR EXTRA-CURRICULAR FIELD TRIP AND ACTIVITIES**

Child Name: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

As the undersigned parent/guardian of the above listed child, I hereby consent to his/her participation in any church sponsored field trip/activity and do forever release, acquit, discharge, and covenant to hold harmless Calvary Baptist Church and all other representatives of Calvary Baptist Church from any and all actions, causes of action and claims on account of, or in any way growing out of, directly or indirectly, all known personal injuries or property damage which I may now or hereafter have as the parent/guardian of the child, and also all claims of right of action for damages which the child has or hereafter my acquire, either before or after he/she has reached his/her age of majority resulting from his/her participation in Calvary Baptist Church field trip/activity. I acknowledge the child's participation in this field trip/activity is voluntary and that his/her participation is not required.

Additionally, in consideration for allowing my child to participate in the field trip/activity, I, as the legal representative of my child, agree to indemnify Calvary Baptist Church and all other representatives of Calvary Baptist Church, in the event that any action, charge, and/or claim is brought against the foregoing, which is in any way related to, arising from and/or growing out of, directly or indirectly, my child's participation in the field trip/activity run by, sponsored by or related to Calvary Baptist Church.

I agree to allow representatives of Calvary Baptist Church for the field trip/activity to authorize medical care of my child. I agree to promptly reimburse Calvary Baptist Church for all expenses incurred for medical services.

Health Insurance Provider: \_\_\_\_\_

Group/Policy #: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Physician Phone #: \_\_\_\_\_

Allergies or Medication for above listed Child: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Phone Numbers: Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

**STATE OF FLORIDA      COUNTY OF TAYLOR**

**THE FOREGOING INSTRUMENT WAS SWORN TO OR AFFIRMED BEFORE ME BY \_\_\_\_\_**

**(   ) WHO IS PERSONALLY KNOWN TO ME OR (   ) WHO PRODUCED \_\_\_\_\_ FOR**

**IDENTIFICATION, ON THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, 2020.**

\_\_\_\_\_  
**NOTARY PUBLIC SIGNATURE**

**STAMP**