I, _____, am the parent or legal guardian of _____ who desires to participate in Vacation Bible School sponsored by Crossroads Church of Long Island.

I understand and acknowledge that Crossroads Church of Long Island will not allow the minor to participate in the Activities without the releasing and holding Church harmless from all liability arising out of participation in the Vacation Bible School. I have investigated the risks involved in the minor's participation in the Activities and fully understand and assume such risks on his or her behalf.

I REQUEST THAT THE CROSSROADS CHURCH OF LONG ISLAND ALLOW THE MINOR TO PARTICIPATE IN THE ACTIVITIES, AND IN CONSIDERATION THEROF AGREE HEREBY TO RELEASE AND FOREVER DISCHARGE THE CHURCH, ITS OFFICERS, AND DIRECTORS, AND ITS EMPLOYEES, AGENTS, AND ANY PARTIES VOLUNTEERING ON BEHALF OF THE CHURCH FROM ALL ACTIONS, CAUSES OF ACTION, INJURIES, CLAIMS, DAMAGES, COSTS OR EXPENSES OF ANY KIND GROWING OUT OF OR RELATED TO ANY SUCH ACTIVITIES IN WHICH THE MINOR PARTICIPATES. I UNDERSTAND THAT THIS IS A FULL AND COMPLETE RELEASE OF ALL INJURIES AND DAMAGES WHICH I OR THE MINOR MAY SUSTAIN AS A RESULT OF HIS OR HER PARTICIPATION IN ANY OF THE ACTIVITIES, REGARDLESS O F THE SPECIFIC CAUSE THEROF.

I further acknowledge and agree that I have given my consent for the minor to participate in the Activities and to remain in the study of the Crossroads Church's representatives while participating in the Activities.

This agreement is binding on the minor's heirs, successors, and personal representatives.

Dated: _____ Signed: _____
(Parent/Legal guardian - individual)

**MEDICAL TREATMENT AUTHORIZATION AND POWER OF ATTORNEY**

In the event the minor suffers injury or condition during his or her participation in the Activities which may endanger his or her life, cause disfigurement, physical impairment, or undue discomfort in medical treatment is delayed, and reasonable attempts to contact me have been unsuccessful, I hereby appoint Crossroads Church & their agents as my agent to act for me and in my name (in any way I could act in person) to make any and all decisions for the minor concerning his or her personal care, medical treatment, hospitalization, and health care. This power of attorney and delegation of authority shall terminate when the agent is first able to contact me.

Specific medical allergies, chronic illness, and other condition: _____

_____

Medical Insurance Carrier _____ Policy/Group #_____

Dated: _____ Signed: _____