

**The Church at Brook Hills**  
**Permission / Release / Medical Authorization Form**

Participant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ SSN: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

**Consent.** I hereby consent to the Participant's participation in \_\_\_\_\_ (the "Activity").

**Assumption of Risk.** I acknowledge that there are certain risks associated with participation in the Activity, which may include, transportation accidents, injuries, loss of personal items, criminal actions beyond the control of The Church at Brook Hills, or other harm that may occur to the Participant. I assume the risk associated with such activities and release The Church at Brook Hills from any liability for such.

**Release / Indemnification.** I hereby, in consideration of such benefits and other good and valuable consideration received through the Participant's involvement in this event, consent to the above listed participation and release absolutely, forever discharge, hold harmless and covenant not to sue The Church at Brook Hills, its directors, employees, agents, volunteers and affiliates ("Brook Hills") from any and all present or future liability, claims, demands, actions, or rights of action, whether asserted by me or a third party arising out of the Participant's participation in event activities (the "Claims"). I agree to indemnify Brook Hills for any such Claims brought by me or a third party from any costs associated with defending or litigating such claims, including but not limited to attorney fees, costs and legal expenses.

**Understanding.** I represent and acknowledge that I have completely read and understand this document and all its terms, that I have had an ample opportunity to obtain the advice of counsel and that by signing this document, I understand that I am relinquishing legal rights and remedies that may have otherwise been available to me. I understand that this Permission / Release / Medical Authorization Form shall be construed as broadly and inclusively as is permitted by applicable law and agree that if any portion of this document is held invalid, the remaining shall continue in full force and effect.

**Media Consent.** I give my consent and permission for the taking of photographs and/or video of Participant during the described event and waive and/or assign any and all rights (including copyright) in such media to Brook Hills. Brook Hills, as the sole owner of such media, shall have the exclusive right to control and determine the use, display, performance, reproduction and dissemination of any such photographs and/or videos.

**Dispute Resolution Agreement.** Brook Hills believes that the Bible commands Christians to make every effort to live at peace and to resolve disputes with each other in private or within the Christian church (see Matthew 18:15-20; 1 Corinthians 6:1-8). Therefore, any dispute, not otherwise released or for which the risk was not assumed, arising from or related to allegations by or against workers, employees, volunteers, church members or their families, will be submitted to biblically based conciliation in accordance with the *Rules of Procedure for Christian Conciliation* of the Institute for Christian Conciliation, a division of Peacemaker Ministries. That forum provides the best opportunity for resolving issues in a fair manner while seeking to preserve or restore the relationships fractured by the dispute and allowing Brook Hills to continue its ministry to all people. (A complete text of the Rules is available at <http://www.hispeace.org/html/geticrul.htm>.)

**CAUTION: READ THIS DOCUMENT CAREFULLY BEFORE SIGNING. THIS IS A GENERAL  
 RELEASE AND INDEMNIFICATION OF CLAIMS.**

**Please check, which applies:**

Parent/Guardian                       Attendee over 19 years of age

Signature: \_\_\_\_\_

If you are a Parent/Guardian of an attendee who is under 19 years of age, please include the following.

Your Name: \_\_\_\_\_

Relationship to attendee: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**2009 Personal Information / Medical History Form**

**Participant's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Home #:** \_\_\_\_\_  
**Mother/Guardian's name:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Home #:** \_\_\_\_\_  
**Employer:** \_\_\_\_\_ **Work #:** \_\_\_\_\_  
**Father/Guardian's name:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Home #:** \_\_\_\_\_  
**Employer:** \_\_\_\_\_ **Work #:** \_\_\_\_\_  
**If Emergency, please notify:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**Family Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**Insurance Company:** \_\_\_\_\_ **Policy #:** \_\_\_\_\_  
**Immunizations:**     Tetanus     Polio Booster     Measles     Mumps     Other: \_\_\_\_\_

**MEDICAL HISTORY** (check box to give appropriate information)

Asthma     Sinusitis     Bronchitis     Kidney trouble     Diabetes     Dizziness  
 Heart trouble     Stomach upset     Hay Fever     Other: \_\_\_\_\_  
**Allergies:**    **Food:** \_\_\_\_\_ **Poison sumac, oak, or ivy:** \_\_\_\_\_  
                   **Insect stings/bites:** \_\_\_\_\_ **Penicillin/Antibiotic:** \_\_\_\_\_  
**Previous operations or serious illnesses:** \_\_\_\_\_  
**Any current medications:** \_\_\_\_\_  
**Special diet (name):** \_\_\_\_\_  
**Childhood diseases:**     Chickenpox     Measles     Mumps     Other: \_\_\_\_\_

**Permission for Treatment:** In the event of sickness, injury or a medical emergency, I hereby authorize any staff member from the Church at Brook Hills to obtain medical treatment for the Participant. I give permission for any doctor or medical professional to provide any treatment he or she deems necessary for Participant. In addition, I hereby assume the financial responsibility for any treatment provided to the Participant.

I, the undersigned, certify that the above information is correct and that I have included all information herein which I believe to be necessary to allow proper treatment of the Participant in the event medical treatment is required.

***Must be signed by Participant or, if Participant is under 19 years of age, by his or her parent or guardian.***

Signature: \_\_\_\_\_ Print name: \_\_\_\_\_