SECC YOUTH MINISTRIES/Vista Seventh-day Adventist Church's Pathfinder Club
PARTICIPATION CONSENT RELEASE & ASSUMPTION OF RISK AGREEMENT

Name: _____

Trip to: _____

Trip date: _____/_____/_____

Departure Time: _____**am/pm** **Return Time:** _____**am/pm**

Transportation:_____

Church/Club: Vista Seventh-day Adventist Church's Pathfinder Club

Cost: $_____

I understand that the aforementioned trip will include participation in the following activities: *(list planned activities).*

1. _____
2. _____
3. _____
4. _____
5. _____

While every reasonable step will be taken to ensure these activities are as safe as possible, I understand that there are inherent risks associated with these activities which may result in serious injury or death. I consent for my child to participate in these activities and assume full responsibility for the inherent risks which exist. I also agree to indemnify and hold harmless the sponsoring institutes, Vista Seventh Day Adventist Church, Vista Pathfinder Club and personally its leadership staff and volunteers and Southeastern California Conference of Seventh-day Adventists from liability arising from accident or injury occurring during this trip. This specifically includes injury arising from negligence on the part of those mentioned above. This recognizes a shared responsibility among church, student and home. This does not include gross negligence on the part of those mentioned above. This does not waive coverage within the policy limits of church accident insurance, which covers church sponsored activities. I further understand that it is not mandatory for my child to participate in all of the activities planned for this trip provided I specify below what restrictions if any I request be placed on my child for purposes of participation in this trips activities. Specific restrictions include:

MEDICAL HISTORY

Child's Birthdate: _____/_____/_____ Date of last physical exam: _____/_____/_____Date of last Tetanus Toxoid Booster: _____/_____/_____

Physician Name: _____ Physician Phone: (_____) _____

Medical Insurance Carrier: _____ Policy and/or Group #: _____

List any medical restrictions: _____

Allergies to drugs or foods:_____

Please describe any prescription medication(s) your child is taking: _____

_____

EMERGENCY CONTACT INFORMATION

Telephone numbers where parent(s)/guardians may be reached: (_____) _____ (_____) _____

Mother's Name: _____ Daytime Phone: (_____) _____ Evening Phone: (_____) _____

Father's Name: _____ Daytime Phone: (_____) _____ Evening Phone: (_____) _____

Alternate Emergency Contact *(in the event parent/guardian cannot be reached):*

Name: _____ Daytime Phone: (_____) _____ Evening Phone: (_____) _____

SIGNATURE

I the undersigned parent/legal guardian having legal custody of the above named minor, do hereby authorize and consent to any X-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act or a Dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the State of California Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power to render care which is the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached. This authorization is given pursuant to the provisions of section 25.8 of the Civic Code of California.

Parent/Guardian Signature: _____ **Date** ____/_____/_____