

MINOR (Under age 19) PARTICIPANT'S NAME: \_\_\_\_\_

**GENERAL RELEASE AND INDEMNIFICATION  
(FOR PARTICIPANTS UNDER AGE 19)**

I hereby represent that I am the parent or legal guardian of PARTICIPANT who is under the age of 19. For and in consideration of the Southern Baptist Conference of the Deaf (SBCD) and Brentwood Baptist Church (BBC) & Brentwood Baptist Deaf Church (BBDC), Brentwood, TN permitting PARTICIPANT to participate in the Southern Baptist Conference of the Deaf to be held July 9-14, 2017 hereafter referred to as "CONFERENCE", I hereby release the SBCD/BBC/BBDC from all claims, demands, suits, causes of action, or judgments which I ever had, now have, or may have in the future or which my heirs, executors, administrators, or assigns may have, or claim to have against the SBCD/BBC/BBDC arising out of or in any way connected with the CONFERENCE, for all personal injuries, known or unknown, property damages, or claims for wrongful death, caused by the acts, omissions, or negligence of the SBCD or BBC/BBDC.

I further agree to indemnify and hold harmless the SBCD/BBC/BBDC from all claims, demands, suits, causes of action, or judgments which PARTICIPANT ever had, now have, or may have in the future or which PARTICIPANT's heirs, executors, administrators, or assigns may have or claim to have against the SBCD/BBC/BBDC arising out of or in any way connected with the CONFERENCE, for all personal injuries, known or unknown, property damages, or claims for wrongful death, caused by the acts, omissions, or negligence of the SBCD/BBC/BBDC and on SBCD's/BBC's/BBDC's behalf and in SBCD's/BBC's/BBDC's name, defend at my own expense any such claims, demands, suits, causes of action, or judgments described above.

**Assumption of Risk.** I am aware of the risks associated with participation in the above event and do hereby voluntarily assume full responsibility for any risk of loss, property damage or personal injury, including death, that may result from participation in event activities, whether caused by SBCD's/BBC's/BBDC's negligence or otherwise.

**Medical Emergency.** In the event of injury or a medical emergency, I understand that the church's group leader, not SBCD or BBC/BBDC, will be responsible for the medical care of all attendees. It will be the church group leader's responsibility to assess medical needs, obtain and consent to appropriate medical care, transport persons in need of medical care and contact parents or guardian of minors. I release SBCD and BBC/BBDC from any and all liability related to medical treatment. In addition, I assume the risk and financial responsibility for any injury resulting from the attendee's participation in all SBCD AND BBC/BBDC events. BBC's/BBDC's guest medical supplement will assist within current/prescribed limitations in a similar way to a secondary carrier. If no insurance is provided by the family or the sponsoring church/organization, BBC's/BBDC's guest medical supplement will also assist within current/prescribed limitations.

**Transportation Release;** I (we) hereby waive, release and discharge SBCD, BBC/BBDC, their staff, employees, and agents from any claim or cause of action of any kind related to transportation of the above minor child, to and from any SBCD/BBC/BBDC events in which said child may participate. Also, I (we) waive any claim against the driver/owner of any vehicle used in the transportation of my child from any action arising during, before, after or otherwise related to the SBCD/BBC/BBDC events.

**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 Waiver and Release 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. To the extent the restriction on filing lawsuits is deemed unlawful, I agree to submit any Claims to a Christian conciliation/mediation organization for binding resolution.

**Media Consent.** I give my consent and permission for the taking of photographs and/or video of me (or my child) during the described event and waive and/or assign any and all rights (including copyright) in such media to SBCD/BBC/BBDC. SBCD/BBC/BBDC, as the sole owners 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.

**DO NOT SIGN UNTIL IN THE PRESENCE OF A NOTARY PUBLIC**

\_\_\_\_\_  
SIGNATURE(S) OF PARENT(S) OR LEGAL GUARDIAN(S)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF NOTARY PUBLIC

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME OF NOTARY PUBLIC  
(CANNOT BE NOTARIZED BY SELF OR SPOUSE)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
MY COMMISSION EXPIRES

SEAL

REQUIRED MEDICAL FORM

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Name of church and group leader or chaperone

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN  
(FOR PARTICIPANTS UNDER AGE 19)

Full Name of Child: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Complete Mailing Address of Child: \_\_\_\_\_

Phone Number: ( ) \_\_\_\_\_ Sex: Male \_\_\_ Female \_\_\_

Father's Name: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Legal Guardian's Name: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Please provide the name of another contact person in case parents cannot be contacted for an emergency situation.

Contact Person's Name: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Relation to Child: \_\_\_\_\_

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INSURANCE INFORMATION

Medical Insurance Company: \_\_\_\_\_ Policy # \_\_\_\_\_

Complete Mailing Address of Insurance Company: \_\_\_\_\_

Phone Number of Insurance Company: ( ) \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Policy Holder's Employer: \_\_\_\_\_

Social Security Number of Child: \_\_\_\_\_

Social Security Number of Policy Holder: \_\_\_\_\_

Medicaid or Medicare Claim Number: \_\_\_\_\_

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MEDICAL INFORMATION

Family Physician's Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Is your child allergic to any food/medication(s)? \_\_\_\_\_ If so, list name(s) of food/medicine:

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Is there any special health information, medication, allergies, we should know about your child:

If so, please explain: \_\_\_\_\_

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Date of last serious immunization: \_\_\_\_\_

Are all immunizations current? YES\_\_NO \_\_\_\_

