Medical Authorization, Participation and Liability Release Form

As parent/guardian, I hereby give my permission for_____,

to participate in **"New Life Christian Academy"** athletic program. I release its staff, counselors, sponsors or leaders from responsibility and liability for any injury or illness that may be sustained during the camp activities as a direct or indirect result of my, or my child's, own negligence or the negligence of third parties. In the event of any emergency, I hereby grant permission for my child to receive first aid and emergency treatment as deem necessary by the Institution's first aid personnel. I authorize **"New Life Christian Academy"** Staff, as an agent for me, to consent to any x-ray, examination, anesthetic, treatment and hospital care advised and supervised by a physician, surgeon or dentist (as appropriate) either at the doctor's office or any hospital. Of course, I understand that an attempt will be made to reach me by phone when a diagnosis is completed. I also understand that all related medical costs are my responsibility.

As parent or guardian, I promise to hold harmless **"New Life Christian Academy"** athletic department and their representatives, volunteers, contributors, and assigns from any and all actions or claims and all liabilities including negligent conduct arising out of or in connection with participation in any activity organized and provided by **"New Life Christian Academy"** athletic department.

I understand and fully accept that there are risks involved in sports, and that accidents and injuries are common and are ordinary occurrences of sports; however I consent to my child to participate.

"New Life Christian Academy" has all the intentions of making each child's athletic experience a positive one.

_____

Parent/Guardian's **printed name**

_____

Parent/Guardian's **signature**

Mailing address, **if different** than street address:

_____

Street/PO Box **City** **State** **Zip Code**

_____**Date**

Proof of Insurance Form

Insurance Company/Holder (if applicable):
_____

Group Name (if applicable):_____

Insurance Policy Number/Group Number:
_____

Physician's Name/Contact Number: _____

Phone: _____ **Effective Date of Coverage:**_____

Relationship to Camper:_____

Other Medical Issues: (Indicate all known medications currently taking, allergies, illnesses, disabilities, physical limitations or medical complications)

_____
_____
_____