

STONE CREEK CHRISTIAN CHURCH

21949 S Highway 213. Oregon City, OR 97045

2026 CONSENT AND LIABILITY WAIVER & MINISTRY MEDICAL RELEASE FORM

CONSENT AND LIABILITY WAIVER

I, _____ hereby give permission to take _____ on the
(parent/guardian) (name of participant)

following activity: _____ **OR** check here ☐ for **ALL 2026 ACTIVITIES**

In consideration of the attendance of my child at the above named activity Stone Creek Christian Church and for allowing my child to participate in this activity, I do hereby release and discharge Stone Creek Christian Church and all of its directors, agents, and adult leaders acting officially or otherwise from any and all claims, demands, actions, or causes of action on account of any injury sustained by my child during said above named activity. I hereby authorize any director, adult leaders, or agent of Stone Creek Christian Church to obtain emergency medical treatment for my child at any time during the above named activity. I understand that an attempt will be made to notify the parents first. If the parents are not available, however, the youth will be taken to the emergency room at the nearest hospital as circumstances may warrant. If any conduct of the participant warrants them to be excused from participating in the event, I assume all responsibility for disciplinary action and picking up my child upon being notified by the adult leader. Should it be necessary for the participant to return home due to medical reasons, disciplinary action or otherwise, I hereby assume all transportation costs.

MEDICAL RELEASE FORM

STUDENT NAME: _____ BIRTH DATE: _____ MALE: _____ FEMALE: _____

HOME ADDRESS: _____

CITY/STATE/ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

I hereby authorize any director, youth counselor, or agent of Stone Creek Christian Church to obtain emergency medical treatment for my child at any time during any activity. I understand that an attempt will be made to notify the parents first. If the parents are not available, however, the youth will be taken to the emergency room at the nearest hospital as circumstances may warrant.

Name & Address of Insurance Company: _____

Policy number: _____

Do any pre-certification, notification, or other requirements exist with respect to the health insurance of participant? If so please specify:

Family Doctor: _____ Phone: _____

Family Dentist: _____ Phone: _____

Date of last tetanus shot: _____

Please list any special medical/health information (including medication & allergies) concerning member listed:

I, the undersigned, hereby acknowledge that I have read the foregoing, understand its contents, and have signed the same as my own free act and deed.

(signature of parent/guardian)

(date)

(cell phone)

(other phone)