

Kingdom Life Community Church
Activity Release Form

For those 18 years of age or older, all parents, and all guardians:

I consent for any of my children listed below to participate in any activity or trip sponsored by Kingdom Life Community Church.

In case of medical need or injury, I authorize the church to arrange for medical or dental services for me and any of my children listed below. I agree that any such expense will be my obligation.

I, individually, or in my capacities as parent or guardian of the below listed children, waive, release, and indemnify the church and all of its agents, directors, officers, employees and volunteers (collectively, "released parties") from all demands, claims, liability, in law or in equity, that have arisen or may arise from any church activity or trip and that involve any damage, loss, or injury to me, my spouse, any of my children, my property, or the property of any of my children. In the same capacities, I promise not to sue any of the released parties for any such demands, claims, or liability. This waiver, release, indemnification, and promise not to sue do not apply to claims of criminal conduct or gross negligence.

I understand that the church may take photographs of me and my family in the course of its activities, and I grant the church permission to publish such photographs in a manner the church deems appropriate.

This activity release form is in effect for any activities that I, or any of my children, may participate in. This form is revocable, prospectively only, by a writing signed by me that bears the date that the revocation is delivered to the church.

I waive, release and indemnify the released parties as identified above from all demands, claims, or liability that have arisen or may arise from any church activity or trip and that involve any damage, loss, or injury to me, my property, or my children's property.

Print Names of Children:

Date of Last Tetanus Shot:

_____	_____
_____	_____
_____	_____
_____	_____

Home Phone: _____ Work: _____ Mobile: _____

Family Physician/Emergency Contact and phone: _____

Medical Insurance Company and Policy # and/or group#: _____

Authorized Medications: _____

Special Considerations or needs (allergies, asthma, etc.): _____

Adult Signature

Date