

# RELEASE, ASSUMPTION OF RISK, AND HOLD HARMLESS

(please fill in all blanks)

I, \_\_\_\_\_ hereby agree to participate in Bethel Christian Center's various programs and activities, and absolve Bethel Christian Center from liability to me because of any illness or injury to me, or for loss or damage to my property resulting from such participation. In the event of my lack of capacity, I hereby authorize Bethel Christian Center's leadership to exercise its discretion in obtaining and/or providing medical attention for me. 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 the authority and release to render care which Bethel's leadership, in the exercise of its best judgment, may deem advisable.

I realize that participating in the various programs and activities of the Center involves many risks including loss or damage to property, illness, injury and death. I hereby assume full responsibility for all financial obligations arising from my participation in the Center's programs and activities. Further, I hereby assume all risks associated with my participation in the Center's programs and activities, and agree to hold harmless Bethel Christian Center Inc., its employees, agents, representatives and volunteers from any and all liability, actions, course of actions, debts, claims or demands of any kind and nature whatsoever which may arise by or in connection with my participation in any activity related to Bethel Christian Center. The terms hereof shall serve as a release and assumption of risk by my heirs, estate, executor, administrator, assignees and for all members of my family.

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## MEDICAL EMERGENCY INFORMATION

PERSON(S) TO CONTACT: (please indicate relationship)

Name \_\_\_\_\_ home phone \_\_\_\_\_ work phone \_\_\_\_\_

Name \_\_\_\_\_ home phone \_\_\_\_\_ work phone \_\_\_\_\_

## MEDICAL INSURANCE INFORMATION

Name of Health Ins. Company \_\_\_\_\_ Policy # \_\_\_\_\_

Does your policy cover foreign countries? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of Physician \_\_\_\_\_ phone \_\_\_\_\_

## PERSONAL INFORMATION

Home Address (street) \_\_\_\_\_ phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Allergies? \_\_\_\_\_

Any medical information needed to be disclosed to medical professionals before treatment? \_\_\_\_\_

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\_\_\_\_\_

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I hereby certify that I am over the age of 18 years, that the forgoing is true and correct, and that I understand and agree to all provisions described herein:

Signature \_\_\_\_\_ date \_\_\_\_\_