Athletes for the Cross
Participant Medical Release

Child's Name: _____ D.O.B.: _____

Address: _____ City/State/ZIP: _____

PARENTS' CONTACT INFORMATION

Father's Name: _____ Mother's Name: _____

Father's Mobile Phone: (___) _____ Mother's Mobile Phone: (___) _____

Father's Home Phone: (___) _____ Mother's Home Phone: (___) _____

Father's Work Phone: (___) _____ Mother's Work Phone: (___) _____

Father's Email: _____ Mother's Email: _____

EMERGENCY CONTACT INFORMATION

In an emergency, when parents cannot be reached, please contact:

Contact 1 Name: _____ Contact 2 Name: _____

Contact 1 Mobile Phone: (___) _____ Contact 2 Mobile Phone: (___) _____

Contact 1 Home Phone: (___) _____ Contact 2 Home Phone: (___) _____

Contact 1 Work Phone: (___) _____ Contact 2 Work Phone: (___) _____

MEDICAL HISTORY

Allergies: _____

Other Medical Conditions: _____

MEDICAL PROVIDER INFORMATION

Physician: _____

Work Phone: (___) _____ Second Phone: (___) _____

Insurance Company: _____ Phone: (___) _____

Policy Holder Name: _____

Policy Number: _____ Group Number: _____

PARENT'S APPROVAL AND MEDICAL RELEASE

Recognizing the possibility of physical injury associated with athletic activities, and in consideration for Athletes for the Cross ("AFC") and its affiliates accepting the registrant for its programs and activities (the "Programs"), I hereby release, discharge, and/or otherwise indemnify AFC/Bethany Church, its affiliated programs and sponsors, their employees and associated personnel, including the owner of the fields and facilities utilized for the Programs against any claim by or on behalf of the registrant as a result of the registrant's participation in the Programs and/or being transported to or from the same, which transportation I hereby authorize.

My child has received a physical examination by a physician and has been found physically capable of participating in the Programs. I hereby give my consent to have an athletic trainer and/or doctor of medicine of dentistry provide my child with medical assistance and/or treatment and agree to be responsible financially for the reasonable cost of each assistance and/or treatment.

Parent/Guardian Signature: _____ Date: _____