

## Consent to Travel

To be completed for participants under the age of 18 (**please print**)

I, \_\_\_\_\_ give my full approval and consent to  
(Parent / Legal Guardian Name)  
\_\_\_\_\_ (our son/daughter) to travel from \_\_\_\_\_  
(Applicant's Name) (Departure City)  
to \_\_\_\_\_ with Grace Community Church from \_\_\_\_/\_\_\_\_/\_\_\_\_ to  
(Destination) M D Y  
\_\_\_\_/\_\_\_\_/\_\_\_\_ .  
M D Y

\_\_\_\_\_  
(Parent/Legal Guardian Signature) M D Y



**This form must be SIGNED and NOTARIZED if participant is under 18.**

I, \_\_\_\_\_, the Parent / Legal Guardian of \_\_\_\_\_,  
(Parent/ Legal Guardian (please print)) (Participant's Name)

have read and understood the above Consent to Travel.

\_\_\_\_\_  
(Parent / Legal Guardian Signature) M D Y

This document signed in \_\_\_\_\_ (county) in the state of \_\_\_\_\_ this \_\_\_\_\_  
day of \_\_\_\_\_ 20\_\_\_\_.

\_\_\_\_\_  
Notary Signature

My commission expires \_\_\_\_\_, 20\_\_\_\_

## Liability Release

### Release of All Claims

We (I) being 18 years of age or older, do for ourselves (myself) (and for and on behalf of my child-participant if said child is not 18 years of age or older) do hereby release, forever, discharge and agree to hold harmless Grace Community church, and the representatives thereof from any and all liability, claims or demands for personal injury, sickness or death, as well as property damage and expenses, of any nature whatsoever which may be incurred by the undersigned and the child-participant that occur while said child is participating in the experience or activity.

Furthermore, we (I) (and on behalf of our (my) child-participant if under the age of 18 years) hereby assume all risk of personal injury, sickness, death, damage and expense as a result of participation in recreation and work activities involved therein.

Further, authorization and permission is hereby given to said church to furnish any necessary transportation, food and lodging for this participant.

The undersigned further hereby agree to hold harmless and indemnify said church, its directors, employees, and agents for any liability sustained by said church as the result of the negligent, willful or intentional acts of said participant, including expenses incurred attendant thereto.



**This form must be SIGNED AND NOTARIZED.**

I, \_\_\_\_\_  
(Trip participant - please print)

(If under 18) I, \_\_\_\_\_, the Parent/Legal Guardian of \_\_\_\_\_  
(Parent/Legal Guardian - please print) (Participant's Name)

have read and understood the above Liability Release.

\_\_\_\_\_  
(Parent/Legal Guardian Signature) M / D / Y

This document signed in \_\_\_\_\_ (county) in the state of \_\_\_\_\_ this \_\_\_\_\_  
day of \_\_\_\_\_ 20\_\_\_\_.

\_\_\_\_\_  
Notary Signature

My commission expires \_\_\_\_\_, 20\_\_\_\_

#sendingGrace  
updated 9/15/13

**This section must be filled out and signed by a parent or guardian if applicant is under 18.**

**This form must be SIGNED and NOTARIZED.**

have read and understood the above Medical Release.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Participant OR Parent/Legal Guardian Signature) M D Y

This document signed in \_\_\_\_\_ (county) in the state of \_\_\_\_\_ this  
\_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_.

\_\_\_\_\_  
Notary Signature

My commission expires \_\_\_\_\_, 20\_\_\_\_

## Medical History

Name: \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Birth Place: \_\_\_\_\_ Family Physician: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Physician Telephone: \_\_\_\_\_ FAX: \_\_\_\_\_

### Provide the Following Information:

Please indicate any other medical conditions that we should know about (Use back of this page if necessary)

Allergies:	yes:____ no:____	Ashma:	yes:____ no:____
Diabetic:	yes:____ no:____	Digestive Disorders:	yes:____ no:____
Epilepsy:	yes:____ no:____	Heart Condition:	yes:____ no:____
Kidney Condition	yes:____ no:____	Physical Handicap:	yes:____ no:____
Other:	yes:____ no:____		

If you have checked any of the above, please explain: \_\_\_\_\_

Are you presently receiving any other prescribed or over-the-counter medication? Yes:\_\_\_\_ No:\_\_\_\_

Please specify: \_\_\_\_\_

## In Case of Emergency Contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

I hereby certify that this information is an accurate representation of my medical history. Should any changes in this occur, I will notify the GCC offices immediately.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
M D Y

\*\*\*\*\*Please attach a photocopy of the front and back of your insurance card.\*\*\*\*\*

\_\_\_\_\_  
Parent/Legal Guardian Signature (if under 18)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
M D Y