



**Children's and Youth Ministry
Medical Release Form
July 2024 – June 2025**

Because of the increasing sophistication of our hospital systems, we have found it necessary to have a signed parental release form in the unlikely event of some serious injury requiring hospital treatment. This release gives us permission to take your child to the nearest available medical facility and have the necessary medical treatment administered. This is not necessary from our perspective, but from your perspective since many hospitals will not administer any medical attention to a minor without some parental consent.

Please read and sign the statement below. This provides permission to seek whatever medical attention may be necessary. It also releases CrossRoads Church of Fergus Falls and/or the church's personnel from any liability against personal injury or loss.

We understand the arrangement and believe that the necessary precautions and plans for the care and supervision of the child will be taken during their participation in CrossRoads Church programs and/or trips. Beyond this, we will not hold responsible CrossRoads Church of Fergus Falls or the person supervising the program and/or trip.

In case of emergency, I understand that every effort will be made to contact me. If I cannot be reached, I hereby give the Children's and/or Youth leadership, staff, or other emergency medical personnel the permission to act on my behalf in seeking emergency medical treatment for this child in the event that such treatment is deemed necessary by the CrossRoads Church volunteer / leadership or church staff. I give permission to those administering emergency medical treatment to do so using those measures deemed necessary. I absolve CrossRoads Church of Fergus Falls, and/or church personnel from Liability in acting on my behalf in this regard so long as they are not grossly negligent.

Name of Child: _____

Parent/Guardian: _____

(Mother) (Father) (Legal Guardian) *circle one

Signature of Parent/Guardian: _____ Date: _____

Insurance Company _____ Policy Number: _____

Work Phone: (_____) _____ - _____ Home Phone: (_____) _____ - _____

If Parent/Guardian are not available, please call person below:

Name: _____ Phone #1: _____ Phone #2: _____

Relationship to Student: _____

Additional comments regarding medical history, allergies, penicillin, drug reactions, etc., which may be needed in treatment: