

Appendix B:

General Events Waiver

YOUTH PARTICIPATION RELEASE AND AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT, UNITARIAN UNIVERSALIST CHURCH OF SOUTH COUNTY

I, _____, the undersigned, hereby represent that I am the Parent/Guardian of _____ (the child). I hereby authorize and grant permission for the child to participate in adult supervised church related activities and functions, and further grant permission for the child to be transported to and from the location by reasonable and safe means.

I agree and hereby do release and hold harmless the Unitarian Universalist Church of South County (UUCSC) and/or any and all adult supervisors for the activity and authorized persons transporting children to and from functions and events, from and for any and all liability which may arise for damages, loss or injuries, either to person or property, which the child may sustain while engaging in the activity conducted including, but not limited to, any damages, loss or injuries that may be sustained through transportation to and from the activity, except as to such injuries or damages arising from the intentional conduct or the sole negligence of UUCSC and/or its supervisors, teachers, leaders or employees. I further agree to assume responsibility for any liability which may arise for damages, loss or injuries, as described herein which may be caused or contributed to by the child to the person or property of others.

Should any injury occur, I grant permission for my child to receive treatment from an appropriate health care provider to be selected by the adult supervisor of the activity, when, in such supervisor's opinion, the need for such treatment is immediate, and when efforts to contact me (us) are unsuccessful. I also agree to pay and be responsible for all medical, hospital, or other expenses, which the UUCSC and/or any and all adult supervisors may incur as a result of securing such treatment.

SIGNATURE: _____ DATE: _____

HOME ADDRESS: _____

HOME PHONE #:(____)_____ EMERGENCY PHONE #: (____) _____

PHYSICIAN: _____ PHYSICIAN PHONE #: (____) _____

EMPLOYER: _____

HEALTH INSURANCE PROVIDER: _____

CHILD'S ALLERGIES: _____

MEDICINE CHILD IS CURRENTLY TAKING: _____

OTHER PERTINENT INFO: _____