

**Global Release, Indemnity and Medical Authorization for ADULTS**

**THIS IS A LEGAL DOCUMENT: READ IT CAREFULLY BEFORE SIGNING**

Date of This Authorization: \_\_\_\_ [MM] \_\_\_\_ [DD] 20\_\_ [YR]

By signing below, I \_\_\_\_\_ [name printed] certify and agree as follows:

1. I am over the age of eighteen and of sound mind.
2. I wish to participate in activities conducted by Christ Gospel Churches International Incorporated, (hereafter "the Church"), and in consideration of the Church's willingness to include me in its activities, I release the Church, its elders, directors, pastors, leaders, representatives, employees, and volunteers from all liability and all claims arising out of any accidents, mishaps, or occurrences that result from the Church activities or are in any way connected with the Church activities, regardless of whether personal injury results or negligence is claimed. I further promise to pay the cost of, and to indemnify, hold harmless, defend and reimburse the Church and its representatives against any claims, suits, demands, losses, or judgments obtained by or on behalf of me.
3. I understand that the Church may take photographs or videos of me while participating in Church activities. I grant permission to the Church to take, use, publish, and distribute photographic likenesses of me for any lawful purpose, including promoting the Gospel, publicity, fundraising, or other ministry and business purposes. I hereby release the Church from all claims of any kind on account of such use. I understand that no compensation will be due me for use of his or her likeness. This release continues until I revoke it in writing; however, I understand that any such revocation will be effective only as to future uses and publications and would not affect the uses and publications that the Church may have already made before it receives such revocation.
4. I also acknowledge that while I am involved in Church activities, an emergency or other situation may arise that requires medical treatment, including surgery, under circumstances where I am not conscious or able to make decisions for myself. Therefore, I hereby authorize a representative of the Church conducting the activity to exercise his or her judgment in seeking and rendering medical assistance and to give any required medical authorization or consent for treatment of myself, even though substantial risks are involved. I acknowledge that the giving of medical authorization and consent is within the scope of this Release. I agree to assume financial responsibility for payment of all medical costs incurred on my behalf.
5. I desire to be able to participate in various church activities without the inconvenience of signing a separate release for each activity. Therefore, I wish this release to cover any and all activities that I choose to participate in, and I desire that this release shall continue in effect until a new release is signed by me, or until I revoke in writing this release. I understand that no revocation will be effective unless I notify the Church in writing.
6. I agree to abide by the rules and policies of the Church activities' program as they now exist or shall be developed from time to time. I understand that if I create a problem or disturbance, I may be asked to leave, and I agree to accept as binding all decisions made by Church leaders in the conduct of the above Church activity.
7. I acknowledge that it is my responsibility to update the church with any changes to my personal information, and I agree to do so in a timely manner.
8. I have read and understood the foregoing release; I agree to be bound by its terms.

Signed by adult over age 18: \_\_\_\_\_ date: \_\_\_\_\_

Name printed: \_\_\_\_\_

**PLEASE COMPLETE COURTESY MEDICAL INFORMATION ON REVERSE SIDE**

## COURTESY MEDICAL INFORMATION SHEET

By completing this form, I understand that this information may be given to medical personnel or to volunteers who assist you. The church may, but is not required to, refer to this information in case of emergency. The church assumes no duty to provide this information to third parties, to administer medication, or to give you medical treatment according to the information herein.

1. Name: \_\_\_\_\_ Birth date: \_\_\_\_\_
2. Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Other phone or mobile: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
Employer Phone: \_\_\_\_\_ Pager # \_\_\_\_\_
3. Medical Insurance Carrier: \_\_\_\_\_  
Carrier Address: \_\_\_\_\_  
Subscriber ID #: \_\_\_\_\_ Group #: \_\_\_\_\_
4. List all major surgeries and illnesses you have had. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. List all medications you are currently taking: \_\_\_\_\_  
\_\_\_\_\_
6. List all your current medical conditions, limitations, & disabilities (hard of hearing, eyesight, coordination, etc)  
\_\_\_\_\_  
\_\_\_\_\_
7. Are you allergic to any medications, bee stings, insect bites, or foods? If so, list.  
\_\_\_\_\_  
\_\_\_\_\_
8. Other individuals to be contacted in case of an emergency:  
Name: \_\_\_\_\_ Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Phone: \_\_\_\_\_
9. Family doctor's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_
10. Date of Last Tetanus shot: \_\_\_\_\_