

**PERMISSION FORM
SHEARER HILLS BAPTIST CHURCH**

(12615 San Pedro, TX. 78216)

STATE OF TEXAS

[(210)-545-2300]

COUNTY OF BEXAR

ACTIVITY OR TRIP -- _____

DATE OF ACTIVITY OR TRIP -- _____

PARTICIPATION PERMIT

In consideration of the benefits to be derived from participation in _____

I, _____, hereinafter referred to as participant, do hereby
{NAME OF PARTICIPANT}

release and forever discharge SHEARER HILLS BAPTIST CHURCH, and all persons associated with SHEARER HILLS BAPTIST CHURCH from any and all actions, causes of actions, claims, and demands for, upon, or by reason of any damage or loss to person or property which may be directly or indirectly sustained during the course of, or as a result of, participation in the above named activity.

It is understood that this release shall be binding upon myself, my assigns, my personal representatives and heirs.

SIGNATURE _____ DATE _____
{NAME OF PARTICIPANT}

ADDRESS _____

PHONE (HOME) _____ (WORK) _____ (EMERGENCY) _____

PARENT'S/GUARDIAN'S WAIVER

(If Participant is under 18 years of age)

I, as parent or guardian of _____, am willing and desirous
{NAME OF PARTICIPANT}

that my son, daughter, or ward, participate in the event referred to above. In consideration of the benefits to be derived from said event or activity, I hereby voluntarily waiver any damage or loss to person or property which may be directly or indirectly sustained in the above named activity.

It is understood that this release shall be binding upon myself, my assigns, my personal representatives and heirs.

SIGNATURE _____ DATE _____
{PARENT OR GUARDIAN}

ADDRESS _____

PHONE (HOME) _____ (WORK) _____ (EMERGENCY) _____

MEDICAL RELEASE FORM

SHEARER HILLS BAPTIST CHURCH 12615 San Pedro, SAN ANTONIO, TX. 78216 (210)545-2300

FUNCTION:
ACTIVITY:
TRANSPORTATION:

DATE:

NAME:

SEX:

AGE:

ADDRESS:

CITY:

STATE:

ZIP:

**This will authorize medical and surgical treatment, as needed,
for my child by physician chosen by the youth minister/sponsor of this church.**

PARENT(S) SIGNATURE:

HOME PHONE NO.

BUSINESS PHONE NO.

Other Person to notify in case of emergency: NAME:

PHONE NO.

NAME and ADDRESS
OF YOUR INSURANCE COMPANY:

PHONE NO.

POLICY NO.

NAME OF INSURED:

MEDICATIONS NOW BEING TAKEN?

ALLERGIES: