



As parent or guardian, I hereby give my permission for _____ to attend *Quicks Clinic*, sponsored jointly by Quicks and Celebration Community Church. I release the staff, counselors, sponsors or leaders of both organizations from responsibility and liability for any injury or illness that may be sustained during the clinic activities as a direct or indirect result of my, or my child's, own negligence or the negligence of third parties. In the event of any emergency, I hereby grant permission for my child to receive first aid and emergency treatment as deemed necessary by the clinic's director. I authorize Quicks' (and/or Celebration Community Church's) staff, as an agent for me, to consent to any x-ray, examination, anesthetic, treatment and hospital care advised and supervised by a physician, surgeon or dentist (as appropriate) either at the doctor's office or any hospital. Of course, I understand that an attempt will be made to reach me by phone when a diagnosis is completed. I also understand that all related medical costs are my responsibility.

As parent or guardian, I promise to hold harmless Quicks, Celebration Community Church, and their representatives, volunteers, contributors, and assigns from any and all actions or claims and all liabilities including negligent conduct arising out of or in connection with participation in any activity organized and provided by Quicks and Celebration Community Church.

I understand and fully accept that there are risks involved in sports, and that accidents and injuries are common and ordinary occurrences in sports. However I consent to my child's participation in the *Quicks Clinic*. I understand the leadership of Quicks and Celebration Community Church have all the intentions of making each child's clinic experience a positive one.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____

Today's Date: _____ Date of Clinic Attended: _____

Address: _____

Emergency Contact Numbers: _____

Insurance Company/Holder: _____

Insurance Policy Number: _____

Physician's Name: _____ Phone: _____

Other Medical Issues: (indicate all known allergies, illness, disabilities, physical limitation or medical complications - use back of form for more space)

Any Prescription Medication: (indicate name, dosage, application times, and what medication is for, if it is needed during Quicks Clinic- use back of form for more space)

All medication sent to Quicks Clinic must be in original container with the pharmacy label on it.