Allyssa DeHaan 3 on 3 Girls Basketball Tournament

Moriah Ministries Event [In partnership with Fellowship of Christian Athletes]

Moriah Ministries
PO Box 333, Allendale, MI
49401 Phone (616-881-6336)

CONSENT AND LIABILITY RELEASE

To be completed by parent or guardian if participant is under 18 years of age, otherwise to be completed by the Participant.
Both parental signatures on the medical release are required.

Parent or Guardian	Participant	Moriah Staff
		Moriah Ministries
Name (herein "parent or guardian")	Name (herein "Participant")	Sponsor
Name (herein "parent or guardian")	Date of Birth / Gender (M/F)	Moriah Ministries Staff (herein "Agent")

Release of Liability

By signing this form I acknowledge that participating in Moriah Ministries 3 on 3 event is a privilege. I understand that there are certain risks of physical injury or illness associated with these activities. In addition, I understand that there may be other risks associated with these activities of which I may not be presently aware. In consideration of your accepting me or my child for participation in the above named program, I hereby waive and release any and all rights and claims for damages that I, as a participant, as parent, or my child may have against Moriah Ministries and its affiliates, volunteers, agents, employees, representatives, successors and assigns for any and all injuries suffered by me or my child that arise out of the subject program, sponsored by Moriah Ministries.

I further agree that in the event that my child or other related person should make any claim in the future against Moriah Ministries, I will personally indemnify, defend and hold harmless Moriah Ministries and its affiliates, agents, employees, representatives, volunteers, successors and assigns against any and all loss and damage, including attorney's fees, arising directly or indirectly from me or my child's actions.

Consent to Treatment *(to be completed regardless of age of Participant)*

By signing this form I, _____, as (circle one) **the Parent /the Guardian / the Participant**, do hereby authorize the above-referenced Agent, acting as the Participant's agent, to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or other emergency medical treatment and hospital care which is deemed advisable by, and is rendered under the general or special supervision of any licensed physician or surgeon; or to consent to an X-ray examination, anesthetic, dental or surgical diagnosis or emergency treatment to be rendered to the Participant by any licensed dentist.

It is understood that this authorization is given in advance of any condition which might occur necessitating treatment, but it is given to provide authority and power on the part of the Agent to give specific consent to any such examination, anesthetic, diagnosis, treatment or hospital care which the aforementioned surgeon, physician and/or dentist, in the exercise of his/her best judgment, may deem advisable. It is also understood that since licensing standards vary between states and nations, the aforementioned surgeon, physician and/or dentist by meet only those qualifications required for licensing in the state or nation where he/she practices.

I hereby authorize any hospital which has provided treatment to the Participant to surrender physical custody of the Participant to the Agent upon completion of treatment.

I hereby agree to pay all costs of medical and dental care incurred by the Agent on behalf of the Participant if said costs are in excess of those covered by any insurance provided to the Participant by the Sponsor Organization.

_____

Signature of Participant Date

_____

Signature of Parent/Guardian - Required Date

_____

Signature of Parent/Guardian - Required Date

Emergency Information *(must be completed regardless of age)*

Insurance Company (other than provided by Project Serve)

Company Name: _____ Policy Number: _____ Insured's Name: _____

Group Name: _____ Group Number: _____ Insured's S.S. #: _____

In case Parent/Guardian is to be notified:

Address: _____ Home phone: (____) _____ Cell phone: (____) _____

_____ Work phone: (____) _____ Email: _____

In case Parent/Guardian cannot be reached, notify:

Name (and relationship) _____ Home phone: (____) _____ Email: _____

Please list all allergies, medications, illnesses, special needs or disabilities of the Participant: Participant's blood type: _____ (not required)

_____

_____