

Zion Baptist Church  
4850 Blagden Avenue, N.W.  
Washington, D.C. 20011  
Adult Activity Participation Form and Release of Liability

Organization/Group: \_\_\_\_\_ Sponsor(s): \_\_\_\_\_

Activity: \_\_\_\_\_ Date: \_\_\_\_\_

Departure Time: \_\_\_\_\_ Expected Return Time: \_\_\_\_\_

Any Cost? \_\_\_\_\_ When Due? \_\_\_\_\_

**Participant Responsibility:**

I, \_\_\_\_\_, agree that I will conduct myself on this activity in a way that would be pleasing to the Lord and a positive representation of my family and Zion Baptist Church. I understand the activity, the mode of transportation, the leadership accompanying the group and all other circumstances relating to this activity. I certify that I am in good health and can participate in all normal activities of the group with the following exceptions \_\_\_\_\_ . I understand that reasonable measures will be taken to safeguard the health and safety of the group, and that I will receive appropriate care in case of an emergency. However, in the event of sickness or accident, I will not hold the group sponsor(s) or Zion Baptist Church responsible. In case of sickness or accident, I authorize the calling in of a doctor and/or the providing of other necessary medical services. I agree to pay for all medical services provided. I agree to release the church from any liability associated with this activity.

***I have read the above statement and understand the information contained therein.***

Printed

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_

Name of person to contact in the event of an emergency:

Name: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

*Please provide emergency health care information on the back of this form.*

9/15/02 ZBC

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Consent for Emergency Medical Treatment of an Adult

Please print all information except where a signature is requested.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City/State \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Person to contact in event of an emergency:

Name: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Do you have any health challenges, limitations, allergies or other conditions?

Yes \_\_\_ No \_\_\_

If yes, please describe:

Does the above restrict any activities? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, to what extent?

Are you taking any medication? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list:

Name of Medication	Reason for Taking	Amount and Frequency
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Health Insurance Co \_\_\_\_\_ ID# \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone# \_\_\_\_\_

In the event of a serious emergency, you will be taken to the nearest available hospital emergency room. You will be responsible for any charges incurred.

***I have read the above statement, and I understand the information contained therein.***

Signature: \_\_\_\_\_ Date: \_\_\_\_\_