

The Fellowship Center

10901 Rhode Island Ave., Unit 77, Beltsville, MD 20705 — Terry L. White, Sr., Senior Pastor

Permission Slip/Activity Liability/Medical Release Form

I give _____ permission to participate in activities of the Youth and Young Adult Church, which include the Children's Ministry, L.O.V.E. (Ladies of Virtuous Etiquette) and S.T.R.O.N.G. (Saved, Talented Righteous, Obedient, New Gentleman) of We Are The Fellowship Center, Inc. on the dates below. I support the Ministry Leader(s) in acting as a responsible leader who is in touch with parent(s)'s as well as children's needs. I also understand that I may give special instructions and requests for any individual activity to the Ministry Leader of the above-mentioned ministries at this number provided by the Ministry Leader:

ACTIVITY LIABILITY RELEASE

It is understood and agreed that the undersigned shall not bring or cause to be brought any action due to any accident or personal injury to my child or property damage that might result from my child's participation in any church-sponsored activity, whether under the direct supervision of the church, its staff, adult youth, children's leaders, parents or other church member.

To restate, the undersigned agrees to accept full responsibility for my child's participation in any church-related-or-sponsored activity and to hold harmless We Are The Fellowship Center, Inc., its staff, adult youth, or children's leaders and any other church member.

MEDICAL RELEASE – TO BE COMPLETED BY PARENT/GUARDIAN ONLY

I do give my permission for _____ to be administered medical aid by a physician or hospital staff if the need arises. I assume responsibility for passing all communication concerning each activity to the parents of any visitor brought by my child or family.

Activity _____ Date(s) _____

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Parent(s) Name(s): _____

Home Phone: _____ Work Phone: _____

Cell Phone Number: _____ Grade in School _____ Age: _____

Emergency Contact Person (Other than Parent): _____

Doctor(s) Name: _____ Doctor's Phone # _____

Ins. Co.: _____ Group #: _____ Policy #: _____

Signature of Parent(s) or Guardian(s) _____

Please list any known medical, food or other allergies or physical conditions plus special requests: _____
