

 **2025 Waiver Form**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_ Birthday\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First Middle

Male or Female (Circle One) Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_

Parent/Guardian Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This consent form gives permission to seek whatever medical attention is deemed necessary, and releases Ponte Vedra Presbyterian Church and its staff of any liability against personal loss.

I understand that there are inherent risks involved in any ministry or athletic event, and I hereby release Ponte Vedra Presbyterian Church, its pastors, employees, agents and volunteer workers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of this event. In the event that he/she is injured and requires the attention of a doctor, I consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is required from a physician and/or hospital personnel designated by Ponte Vedra Presbyterian Church, I agree to hold such person free and harmless of any claims demands or suits for damages arising from the giving of such consent. I also acknowledge that I will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the heath insurance provider. Further, I affirm that the health insurance information provided above is accurate at this date.

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