

**Parent Info**

Name(s): \_\_\_\_\_  
Address: \_\_\_\_\_  
City/St/Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Father Cell: \_\_\_\_\_  
Mother Cell: \_\_\_\_\_

2010-2011  
**PIONEER CLUBS® Permission Slip**  
Christian Family Chapel  
for  
\_\_\_\_\_  
(person's name)

**Waiver and Release of Liability**

I, \_\_\_\_\_, give permission for the person named above to attend Christian Family Chapel and to participate in various activities sponsored by CFC during the year. This includes permission for my child to be transported to and from Christian Family Chapel, and Christian Family Chapel sponsored activities and to be transported to and from any Land o' Sunshine CAMP CEDARBROOK® events. I understand that certain activities carry the risk of injury, including but not limited to: use of kitchen stoves, use of craft tools, fire building, biking, water sports, pony rides and horseback riding. I voluntarily release, acquit and forever discharge Christian Family Chapel and its directors, elders, employees, members and agents from all manner of suits, actions, demands and liabilities which may arise from my child participating in or being transported to and from activities at Christian Family Chapel, 10365 St. Augustine Road, Jacksonville, Florida, 32257 or any Christian Family Chapel sponsored event.

**Authorization and Consent for Treatment (For Adults and Minors)**

I have read the above waiver and Release of Liability and agree to its provisions. In addition, in the event of an accident or illness and the parent or guardian cannot be reached, I give permission for Christian Family Chapel leaders to apply first aid and/or, if I cannot be reached in an emergency, to take my child to a doctor or hospital for treatment. I also give permission for Pioneer Club leaders to apply first aid and/or, if I cannot be reached in an emergency, to take my child to a doctor or hospital for treatment.

I understand that Christian Family Chapel's medical insurance is "second pay" and that any family policy will be billed first. I assume all financial responsibility for the decisions made to secure emergency care or treatment for the above-named person.

**Emergency Contact Information (other than parents):**

\_\_\_\_\_  
Name Telephone Relationship

**Medical Information**

Allergies \_\_\_\_\_  
Insurance Carrier \_\_\_\_\_  
Name of Insured \_\_\_\_\_ Relationship to club member \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_

**Please Sign Below**

Signed \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

(note – witness should not be spouse)

Child's Last, First Name