

# OFF-CAMPUS RELEASE

Concerning: \_\_\_\_\_  
Name of Student

**THIS DOCUMENT IS APPLICABLE TO THE PERIOD OF TIME DURING WHICH YOUR CHILD ATTENDS CALVARY CHAPEL CHRISTIAN SCHOOL.**

1. I authorize Calvary Chapel Christian School by its representatives to obtain any emergency medical care necessary.
2. I agree that the expense of any medical treatment will not be born by Calvary Chapel Christian School or any of its employees.
3. I will not hold Calvary Chapel Christian School or any of its employees liable for any injury sustained by the registrant while traveling to, participating in, or returning from any Calvary Chapel Christian School functions.
4. I may be reached in case of emergency at: \_\_\_\_\_  
Phone number

The registrant is covered by: \_\_\_\_\_  
Name of insurance company

Policy Number: \_\_\_\_\_

5. I understand that every effort will be made to contact me regarding medical treatment authorization. If I am unavailable, please consider the following list of pertinent medical information: (Please include any allergies, last tetanus shot, medication, recent injuries, etc.)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Parent/Guardian

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
My commission expires NOTARY PUBLIC, STATE OF FLORIDA

- ( ) Personally Known
- ( ) Produced Identification Type \_\_\_\_\_  
Number \_\_\_\_\_