

# FOOTHILLS CHRISTIAN ELEMENTARY SCHOOL

P. O. Box 2029  
10404 Lake Jennings Park Road  
619-561-2295 619-561-0238 fax

## MEDICAL RELEASE AND LIABILITY FORM

|                                  |                 |
|----------------------------------|-----------------|
| Activity:                        |                 |
| Dates                            |                 |
| Location of travel if applicable | San Diego       |
| Type of transportation           | Private Vehicle |

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

The undersigned represents to Foothills School, that he/she is a natural parent or legal guardian of the above named minor child; and,

The undersigned does hereby consent to such minor child taking part in the noted activity, with the full understanding that insofar as such activity will involve sporting activities, travel and mingling with other individuals and group, that there is always the risk of injury, illness and loss, and possible consequent expense for medical diagnostic and curative treatments, and incidental loss and expense; and , in behalf of such minor assume the risk of such expense and does hereby wholly release **Foothills Christian School** from any responsibility or liability and waives any claims or causes or action against it or its agents that might arise on account of loss, injury or expense occasioned by any sort of accident or other circumstance involving such child, and agrees to hold harmless ,Foothills Christian School and the above mentioned names, in the event any such claim should arise; and,

The undersigned agrees to abide by the rules and regulations, supervision and discipline set and applied by Foothills Christian School and its agent; and, does hereby authorize Foothills Christian School or its staff members or other agents to arrange for any consent to x-rays, examinations, anesthetic, dental, medical or surgical diagnosis, and treatment, and hold harmless Foothills Christian School. The undersigned will furnish payment or insurance for, and such payment, at his or her own expense.

|  |             |     |
|--|-------------|-----|
| Address:                                     | City        | Zip |
| Home Phone                                   | Cell Phone: |     |
| Doctor                                       | Phone       |     |
| Insurance Information (if applicable):       |             |     |
| Person to contact if parent is not available |             |     |
| Day phone                                    | Cell Phone  |     |

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date