



**ADULT FORM**

*Individual Consent & Medical Release Form*

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

**Please print all information in Blue or Black Ink ONLY**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

**EMERGENCY CONTACT:** \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_

**ADDITIONAL INFORMATION:** (List any know allergies or medical conditions)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**BACKGROUND CHECK & INFORMATION**

I understand that by signing this form I could be subject to a background check or other investigation of my history. If I will be involved in providing transportation for minors to/from any church related event, I understand that I may be required to furnish a copy of my driver's license. I also understand that my ability to participate in some activities may be contingent on what is found in my background check.

**MEDICAL RELEASE**

I am responsible for my own health care decisions and am authorized to consent to the services to be rendered. I represent that my consent to and agreement to pay for the dental, medical, or hospital care or treatment to be rendered to me is legally sufficient and that no consent from any other person is required by law.

**PHOTO RELEASE**

I give permission for my likeness to appear in candid shots while participating at WPC with the understanding that such photos may appear in church publications, including the website, pictorial directories, brochures, or promotional DVDs.

\_\_\_\_\_ I **AGREE** TO THE PHOTO RELEASE      \_\_\_\_\_ I **DO NOT AGREE** TO THE PHOTO RELEASE

**I consent to participation in Westminster Presbyterian Church's activities and I expressly waive any claim for compensation or liability for any injuries or illnesses sustained during my participation.**

**Signature:** \_\_\_\_\_