Cornerstone Christian
Athletic Liability and Medical Release Form

Name of Athlete: _____

ATHLETIC LIABILITY RELEASE

I/We, the parent(s)/guardian(s) of _____, do attest that my/our child is in good physical health.

I/We understand that participation in sports can result in injury. I/We hereby give my/our consent to allow my/our child to participate in Cornerstone Christian Academy ("CCA") athletic programs not specifically excluded by the parent or physician on the medical history forms. I/We assume all of the risks, hazards, and financial obligations incidental to the activity of the sport.

I/We hereby release, absolve, indemnify, and hold harmless CCA and the coaches, teachers, administrators, board members, volunteers, and participants and any other person or entity duly acting on behalf of CCA from any claims arising out of any injuries, of any nature, to my/our child while participating in CCA activities.

MEDICAL CONSENT FORM

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, X-ray examinations and immunizations for the above named student if I, as a parent/guardian, am not present. In the event of serious illness, the need for major surgery or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary in the best interest of the above named student may be given.

In the event that an emergency arises during a practice session, every effort will be made to contact the parents/guardians as soon as possible. Permission is also granted to cornerstone Christian Academy to provide the needed emergency treatment to the athlete prior to his/her admission to the medical facilities.

Parent/Guardian Signature _____ Date: _____

Parent/Guardian Signature _____ Date: _____

Phone numbers where parents/guardians may be reached:

Office _____ Cell _____

Home _____ Other _____

Family Physician: _____ Phone: _____

Insurance Company: _____
Group/Policy Number: _____