



**CROSSWAY  
SPORTS**

## Waiver of Liability

### Minor Participation Authorization and Consent to Emergency Medical Treatment

I, the undersigned, certify that I am the parent or legal guardian of \_\_\_\_\_  
(hereafter the "minor child").

I hereby give my consent to have my minor child participate in the following CrossWay Sports  
activity: \_\_\_\_\_ (hereafter "the activity") on  
or about \_\_\_\_\_, 20\_\_\_\_\_.

I recognize that there are risks involved in participating in this activity and hereby assume all risk of injury,  
harm, damage, or death to my minor child in connection with his/her participation in this activity.

To the fullest extent permitted by law, I release CrossWay Sports and its partner churches, including The  
Church at Schilling Farms, First Baptist Church of Collierville, Covenant Baptist Church and Emmanuel  
Baptist Church, as well as their trustees, officers, directors, employees, agents and representatives from  
any injury, harm, damage or death which may occur to my minor child while participating in the activity  
and agree to save and hold harmless these organizations, its trustees, officers, directors, employees,  
agents and representatives from any claims arising out of my minor child's participation in the activity.

Further, being the parent or legal guardian of the minor child, I do consent to any medical, surgical, x-ray,  
anesthetic, or dental treatment that may be deemed necessary for my minor child. I understand that  
efforts will be made to contact me prior to treatment but, in the event I cannot be reached in an  
emergency, I give permission to the activity leader to make the decisions necessary for treatment.  
Should there be no activity leader available, I give permission to the attending physician to treat my minor  
child. As parent or legal guardian, I understand that I am responsible for the health care decisions of my  
minor child and agree that my insurance plan is the primary plan to pay for the medical, dental, or hospital  
care or treatment that is given to my minor child. Any insurance policy of the church or organization  
sponsoring this event will be used as the secondary coverage.

Family Physician: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Health Insurance Provider: \_\_\_\_\_

Special Medical Conditions/Allergies: \_\_\_\_\_

Current Medications Being Taken: \_\_\_\_\_

Person authorized to act on your behalf in an emergency: (optional)

Name: \_\_\_\_\_

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

Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

Witness \_\_\_\_\_

Witness \_\_\_\_\_