STAFFORD CROSSING COMMUNITY CHURCH
CONDITIONS OF PARTICIPATION and MEDICAL CONSENT FORM

Student's Name:

Custodial Parent/Guardian Name:

Primary Contact Phone Number

Alternate:

Emergency Contact Name:

Contact #:

Conditions of Participation

I am the parent or legal guardian of the person named above, a minor, and have given my consent for him/her to attend the following Stafford Crossing Community Church Student Ministry event:

Event name: MS CAYA Night Date: February 7, 2026 Location: Sky Zone, Fredericksburg, VA

The Student Pastor/Event Leader reserves the right to dismiss a student who is in his opinion has violated the rules set for behavior for the event or is a hazard to the safety, rights, or positive experience of other participants. In the case of dismissal, parents/guardians will be responsible to arrange and bear the expense of the participant's travel home.

I give permission for Stafford Crossing to use any likeness or image of my child in promotional material. Personal information associated with image will not be published without specific consent.

Care is taken for the safety and good health of all those participating in our events, but in the event of accident or sickness, Stafford Crossing is hereby released from any liability.

Medical Info

Allergies
Food

Medication

Other (e.g. insect stings, hay fever, asthma, latex)

Medications Participant will be taking medications during event? YES NO (circle)

If YES, List all medications (please include dosage and frequency if known)

Additional Information (provide any additional info about participants behavior and physical, emotional, or mental health that we should be aware of)

Restrictions Explain any restrictions to activity (e.g. what cannot be done, what limitations or adaptation are necessary)

Medical Release

I authorize the use of over-the-counter medications (e.g. Tylenol, Benadryl, Imodium, Eye Drops) to be given as needed at the discretion of the Student Pastor or Event Leader. (Not authorized if these medications are listed as allergen to restricted)

Each participant is required to be covered by his/her own personal medical insurance. All expenses for care are the responsibility of the participant.

I understand that students who have potentially life threatening conditions (such as peanut allergies) are required to be able to manage their exposure to those substances and have medications readily available for use.

In the event that he/she is injured while attending these events and requires the attention of a doctor, I consent to any medical treatment as deemed necessary by a licensed physician. In the event treatment is called for, which a physician and/or hospital personnel refuses to administer without my consent, I hereby authorize

Mason Cratch

to give such consent for me if I cannot be reached by telephone or, because of an emergency, there is not time or opportunity to obtain consent. In the event it becomes necessary for that person to give consent for me, I agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent so long as the treatment is administered by or under the supervision of a licensed physician.

This health history is correct and complete as far as I know, and the participant herein described has permission to engage in all event activities except as noted.

I have read, understood and accept the conditions of participation and medical release.

Signature:

Insurance Co:

Policy ID/Number:

Insurance Phone #: