Participant"s
Name_____

# Permission/Liability Release/Medical Consent Form

**Permission:** I give permission for the participant to engage in Living Faith Fellowship and Outreach Ministries, Inc. (LFFOM) or Strategic Global Assistance, Inc. (SGA) activities. I understand that LFFOM or SGA's leadership and staff will make the participant's safety and well-being a top priority and I agree not to hold LFFOM or SGA and its leaders or staff responsible for any mishap or accident that may occur, either on or off the church's premises. I choose to put the participant in God's care for his/her safety.

**Liability Release:** I do, hereby, for the participant/myself, respective heirs, executors and administrators, waive, release, and forever discharge any and all rights and claims for damages of any kind which the participant/I may have or which may hereafter accrue to the participant/me against LFFOM or SGA, their members, representative officers, agents, representatives, successors, and/or assigns, individually or collectively, for any and all damages and liabilities which may be sustained and suffered by the participant/me in connection with our association with/or arising out of the traveling to, participation in, and returning from any activity sponsored by LFFOM or SGA.

**Medical Release:** I authorize LFFOM or SGA and their employees, agents, and authorized representatives to consent to any emergency medical treatment to be rendered to the participant named below should that be deemed necessary. I assume responsibility for any and all costs for such emergency medical treatment.

In witness of the participant's/my consent and agreement to the matters stated in all of the preceding statements, the participant/I have subscribed my/our signature(s) below.

Participant's Name_____

Street Address_____

City_____State_____Zip Code_____

Home Phone_____Business Phone_____Email_____

**Participant's Signature**_____Date_____

Emergency contact_____ Wk Ph_____Hm Ph_____

Family physician_____Wk Ph_____Hm Ph_____

Medical insurance company_____

Pertinent medical information (diabetes, allergies, medications, etc.)_____

**If participant is under 21 years of age, please complete the following:**

Parent's or Guardian's Name_____

Street Address_____

City_____State_____Zip Code_____

Home Phone_____Business Phone_____Email_____

**Parent's/Guardian's Signature**_____Date_____