



## LBT Live Clue Event

- What:** A trip to Lima Baptist Temple for 9-12<sup>th</sup> grade students to play live-action Clue.
- When:** Saturday, November 7, 2020 from 5pm - ? Drop off in the Hopeshakers room at 5pm. Students will contact parents on the way back for pickup at Shawnee Alliance.
- Cost:** \$12 (covers the cost of playing Clue plus pizza and pop at Rapid Fired Pizza)
- Register:** [www.shawneealliance.com/events](http://www.shawneealliance.com/events) by November 5, 2020.

**Contact:**

Josh Kennedy  
Student Ministry Leader  
567-712-9089

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Please keep the back of this page for your own reference.

## Activity Participation Agreement

### Activity Information

Shawnee Alliance Church  
4455 Shawnee Road  
Lima, OH 45806  
(419) 991-6546

Lima Baptist Temple  
982 Brower Rd  
Lima, OH 45801

Name of Ministry: Student Ministry (Sr. High)

Ministry Leader: Pastor Josh Kennedy

Activity: LBT Live Clue Event

Date(s) and location of activity: November 7, 2020 - Parents drop off & pick up at Shawnee Alliance in the Hopeshakers room. Event is at Lima Baptist Temple, 982 Brower Rd, Lima.

### Participant Information *(To be completed by participant or authorized guardian)*

Name of participant: \_\_\_\_\_

Grade: \_\_\_\_\_ Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Names of parents/guardians: \_\_\_\_\_

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

Telephone: \_\_\_\_\_

Name of emergency contact: \_\_\_\_\_

Daytime telephone: \_\_\_\_\_ Evening telephone: \_\_\_\_\_

List any allergies or medical conditions: \_\_\_\_\_

Is sponsor authorized to approve medical treatment? ☐ Yes ☐ No

Is participant covered by personal/family medical insurance? ☐ Yes ☐ No

If yes, name of insurer: \_\_\_\_\_

Policy or group number: \_\_\_\_\_

## Participant Agreement

As parent/legal guardian of \_\_\_\_\_, I give my permission for my child to be involved in the activity/trip mentioned above. I acknowledge that participation in the activity described above (the "Activity") involves risk to the Participant (and to Participant's parents or guardians, if Participant is a minor), and may result in various types of injury including, but not limited to, the following: sickness, bodily injury, death, emotional injury, personal injury, property damage and financial damage.

In consideration for the opportunity to participate in the Activity, we the Participant and parent/guardian acknowledge and accept the risks of injury associated with participation in and transportation to and from the Activity. We accept personal financial responsibility for any injury or other loss sustained during the Activity or during transportation to and from the Activity, as well as for any medical treatment rendered to the Participant that is authorized by the Sponsor or its agents, employees, volunteers, or any other representatives (collectively referred to hereinafter as the "Activity Sponsor"). Further, we release and promise to indemnify, defend, and hold harmless Shawnee Alliance Church for any injury arising directly or indirectly out of the described Activity or transportation to and from the Activity, whether such injury arises out of the negligence of the Activity Sponsor, the Participant, or otherwise.

I have reviewed the Personal Conduct Agreement with my child and have encouraged them to abide by their covenant. I therefore understand that if they chose not to abide by the rules set forth in the Personal Conduct Agreement, or refuse to follow the directions of Shawnee Alliance Church Staff and appointed volunteers, disciplinary action will be taken. Should my child continue to be a disruption, I agree to be held financially responsible for any and all costs associated with their early return.

If a dispute over this agreement or any claim for damages arises, we agree to resolve the matter through a mutually acceptable alternative dispute resolution process. If we and the Activity Sponsor cannot agree upon such a process, the dispute will be submitted to a three-member arbitration panel for resolution pursuant to the rules of the American Arbitration Association.

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

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

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

*Participant (and parents/guardians if Participant is a minor)*

## HopeShakers Student Impact

### Medical Release Form

I, \_\_\_\_\_, hereby give permission for any and all medical  
Parent/guardian's name

attention to be administered to my child, \_\_\_\_\_  
Child's full name

in the event of accident, injury, sickness, or other emergency under the direction of the Shawnee Alliance Church, until such time as I may be contacted. I also assume the full responsibility for the payment of any and all expenses incurred in connection with such treatment. This release is effective for one year from the signing date.

#### Child Information:

Grade: \_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

#### Parent/Guardian Information:

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

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ Other Phone: (\_\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

#### Insurance Information:

Company: \_\_\_\_\_

Policy/Contract Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ Telephone: (\_\_\_\_\_) \_\_\_\_\_

#### Physician's Information:

Name: \_\_\_\_\_ Telephone: (\_\_\_\_\_) \_\_\_\_\_

**Medical Conditions:**

Known allergies: \_\_\_\_\_

\_\_\_\_\_

Medical conditions: \_\_\_\_\_

\_\_\_\_\_

Special needs: \_\_\_\_\_

\_\_\_\_\_

Medications being taken: \_\_\_\_\_

If I cannot be reached, the following person(s) are designated to act on my behalf:

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

Telephone: (\_\_\_\_\_) \_\_\_\_\_ Other Phone: (\_\_\_\_\_) \_\_\_\_\_

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

Telephone: (\_\_\_\_\_) \_\_\_\_\_ Other Phone: (\_\_\_\_\_) \_\_\_\_\_

**Consent for medical treatment (minor):**

As the parent/legal guardian of the above named child, I hereby give my consent for emergency medical care prescribed by a duly licensed hospital, doctor of medicine or doctor of dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb or well-being of my son or daughter.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

***Please provide a copy of your insurance card (both front and back)  
and return with this form.***