

**COLONIAL CHRISTIAN SCHOOL
2023-2024 Medical Release Form**

8140 Union Chapel Road, Indianapolis, IN 46240 (317) 253-0649 • FAX (317) 254-2840 • www.ccsindy.org

THIS FORM TO BE COMPLETED BY PARENT

NAME: _____

GRADE (2023-2024) _____ BIRTHDATE _____

Medical conditions to be aware of: _____

My child **may not** participate in the following activities:

Special Instructions and medications: _____

Date of last **Tetanus** or booster: _____

Insurance Company Information:

Company Name: _____

Policy Number: _____

Any other policy numbers necessary for treatment:

Phone Numbers:

Father Work: _____ Cell: _____

Mother Work: _____ Cell: _____

Home: _____

CCS ATHLETIC MEDICAL RELEASE 2023-2024

Grade: _____

I, hereby, give my permission for _____ to attend the officially scheduled athletic
(Name of Participant)

events with the Colonial Christian School coach and teammates. This includes school transportation to and from the event, attendance at the event, and scheduled stops along the way (e.g., restaurant). This permission applies to the (fall, winter, or BOTH) _____ seasons for the 2023-2024 school year. I assume full responsibility for my son/daughter while participating in this activity and agree that he/she be in submission to those in authority. I hereby release and forever discharge and hold harmless Colonial Hills Baptist Church (CHBC), Colonial Christian School (CCS), its staff and administration of any and all liability and responsibility for injuries, sickness, and or accidents while my son/daughter participates in or results from such participation. I understand that CHBC, CCS, its staff and administration does not assume any responsibility for or obligation to provide me with financial or other assistance, including but not limited to medical, health, or disability benefits or insurance of any nature in the event of participants injury, illness, death or other damages and waive any such claim for compensation or liability on the part of CHBC/CCS beyond what may be offered freely by CHBC/CCS (secondary student accident insurance coverage) in the event of such injury or medical expenses incurred.

As a parent or guardian, I do, herewith, authorize the treatment by a qualified and licensed medical doctor of the following student, in the event a medical emergency which, in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authorization is granted only after a reasonable effort has been made to reach me.

(Date)

(Signature of Parent/Guardian)

(Relationship to Participant)

I, hereby, agree to observe all regulations and to comply with those in authority while participating in these events.

(Date)

(Signature of Participant)

A NEW FORM IS REQUIRED EACH YEAR FOR EACH PARTICIPANT.