

Grace Temple Church

RELEASE AND MEDICAL POWER OF ATTORNEY

1. I agree to participate in the activity described on the reverse and release from all liability and indemnify the Pastor of Grace Temple Church, inc. ("the Pastor"), both individually and as trustee for Grace Temple Church and all ministries of Grace Temple Church, and their officers, agents, representatives, volunteers, and employees from any and all liability, claims, judgments, cost or expenses, including attorney fees, arising out of any injury or illness incurred by me while participating in or traveling to or from the activity.

2. I agree to cooperate with the Pastor or his agents in charge of the activity.

3a. I appoint the Pastor or his agents who are acting as leaders of the activity as my attorney in fact to act for me in my name and my behalf, in any way that I would act if I were personally present, with respect to the following matters if any injury, illness or medical emergency occurs during the activity or related travel:

(i) To give any and all consents and authorizations to any physicians, dentist, hospital or other persons or institutions pertaining to any emergency medications, medical or dental treatments, diagnostic or surgical procedures or any other emergency actions as our attorney shall deem necessary or appropriate for my best interest.

(ii) I understand that the agents of Grace Temple Church, Inc. will make a reasonable attempt to contact my family as soon as possible in the event of a medical emergency involving me.

3b. This power of attorney shall lapse automatically upon completion of the activity and related travel.

4. I agree that the Pastor or his agents may use my portrait or photograph for promotional purposes and functions.

I have carefully read this statement, and my signature acknowledges that I fully understand the content and meaning.

Signature of Participant _____ Date _____

Address _____ City _____ Zip _____

Place of Employment _____

Address _____ City _____ Zip _____

Phone: (w) _____ (h) _____ Emergency Contact _____

Relationship _____ Phones _____

Medical Information

Allergies _____ Medications _____

Chronic Conditions (e.g. epilepsy, diabetes) _____

Medical Insurance Co. _____ Policy No. _____

Member's Name _____ Phone _____

Family Doctor _____ Phone _____