BAPTIST GENERAL CONVENTION OF THE STATE OF OKLAHOMA

BAPTIST COLLEGIATE MINISTRIES

APPLICATION AND RELEASE

Sponsor: [Name]\_ Baptist Collegiate Ministries (hereafter “BCM” or “BSU”)\_\_\_\_\_\_\_\_

Valid January 1 through December 31, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (year) for all BCM activities.

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_

# Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School Attending: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In Emergency Notify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell or Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_

1. Does Applicant have any known allergies or is Applicant unable to take any medication?

\_\_\_ Yes \_\_\_\_ No

If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Does Applicant presently take any medications regularly? \_\_\_\_ Yes \_\_\_\_ No

If yes, what medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For what reason? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. List any other medical condition(s) that would be helpful to know: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Date of last tetanus immunization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Applicant has current medical insurance coverage through:

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

Name on Insurance Policy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address for Medical Claims (see back of insurance card): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

6. Does your insurance company require notification prior to emergency health care at a hospital? \_\_\_\_\_\_\_\_\_\_\_\_ If yes, Phone Number? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby apply for an opportunity to attend BCM activities. I understand that the BCM is affiliated with the Baptist General Convention of the State of Oklahoma (hereafter “BGCO”). This Application and Release is voluntarily and freely made with the knowledge of the risks inherent in participating in the activities, including, but not limited to: (1) the possibility of bodily injury or property damage; and (2) the possibility of being injured in an accident while traveling in any form of transportation to the activities, during the activities, or returning from the activities.

I hereby agree to participate with the BCM during activities. I hereby authorize the BCM to obtain, through a health care provider of the BCM’S own choice, any first aid or emergency medical care that may become reasonably necessary for me in the course of such activities or such travel. If such emergency care is provided, I understand that my health insurance information will be given to the health care professional and that any expenses not covered by my insurance shall be my responsibility. I understand that neither the BCM nor the BGCO will be obligated to pay any health care professional or me for any medical expenses incurred.

I FULLY ACCEPT AND ASSUME ALL RISKS AND ALL RESPONSIBILITY FOR LOSSES, COSTS, OR DAMAGES, INCLUDING DAMAGES FOR PHYSICAL INJURY, INCURRED AS A RESULT OF MY ACCOMPANYING THE BCM TO AND FROM ACTIVITIES AND OF MY PARTICIPATION IN ACTIVITIES.

I RELEASE AND HOLD HARMLESS THE BCM, THE BGCO, THEIR PREDECESSORS IN INTEREST, SUCCESSORS IN INTEREST, PRESENT AND FORMER AFFILIATES, AND ALL OF ITS PRESENT OR FORMER DIRECTORS, OFFICERS, AGENTS, EMPLOYEES, REPRESENTATIVES, SUCCESSORS OR ASSIGNS, AND ANY OWNERS OR LESSORS OF PREMISES ON WHICH THE ACTIVITIES TAKES PLACE, FROM ANY AND ALL LIABILITY, INCLUDING LIABILITY FOR PHYSICAL INJURY, ANY LOSSES, CLAIMS, DEMANDS, COSTS, OR DAMAGES THAT I MAY INCUR AS A RESULT OF MY PARTICIPATION, INCLUDING BUT NOT LIMITED TO THE NEGLIGENT, GROSSLY NEGLIGENT, OR INTENTIONAL CONDUCT OF ANY OTHER PARTICIPANT IN THE ACTIVITIES.

I understand that my image may be included in a video or in photographs that may be made during activities. I understand that a promotional or highlight video may

be available during or after activities. I give consent for my image appearing on videos, promotional resources, or on web sites endorsed by the BCM or BGCO.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant Signature Date

If the Applicant is under the age of 18 years, a parent or legal guardian of the Applicant must sign and date this Application and Release. By their signature, such parent or legal guardian agrees to be bound by all of the terms of the Application and Release on behalf of such parent or legal guardian and on behalf of such minor Applicant.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Legal Guardian Signature Date