

32068 King Road,
Abbotsford, BC
V2T 5Z5
604-864-0030
www.kingroad.ca



KingRoad
church

Youth Ministry Registration 2024-2025
(Please complete one form/family)

Names of Parent(s)/Guardian(s): _____

Full Address: _____

E-mail: _____

Mom's Cell: _____ Dad's Cell: _____

Contact name & number (other than parents) for pickup/emergencies:

School that children attend: _____

Children Involved in Youth Ministries
(List all children Grade 6 - Grade 12)

Name	Gender	Birthdate (M/D/Y)	Grade in Fall	Allergies

PHOTO RELEASE: We enjoy taking photos of the children. These photographs may be used in various ways, including but not limited to: bulletin boards, gifts to children and families, web-site updates, and future promotion material. I, _____ (parent/guardian signature) authorize that photographs may be taken of my children listed on this page.

SOCIAL MEDIA/TEXT/EMAIL: Communication through social media/text/email may be necessary throughout the year as the schedule/weather/etc may change.

I, _____ (parent/guardian signature) authorize King Road Church youth leaders

to contact my children listed on this page via social media/text/email.

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GENERAL RELEASE AND HOLD HARMLESS AGREEMENT – MINOR

I, _____, am the parent or legal guardian of _____ (the “minor”- name all), who desires to participate in various programs, events or activities (hereinafter collectively referred to as the “Activities”) operated by King Road MB Church on-site for the year **Sept. 2024- June 2025**.

I understand and acknowledge that King Road MB Church will not allow the minor to participate in the Activities without releasing and holding King Road MB Church harmless from any liability/sickness arising out of participation in the Activities. I understand there may be risks involved in the minor’s participation in the Activities and fully assume such risks on his or her behalf.

I REQUEST THAT KING ROAD MB CHURCH ALLOW THE MINOR TO PARTICIPATE IN THE ACTIVITIES, AND IN CONSIDERATION THEREOF AGREE HEREBY TO RELEASE AND FOREVER DISCHARGE KING ROAD MB CHURCH, ITS OFFICERS AND DIRECTORS, AND ITS EMPLOYEES, AGENTS AND ANY PARTIES VOLUNTEERING ON BEHALF OF THE CHURCH FROM ALL ACTIONS, CAUSES OF ACTION, INJURIES, CLAIMS, DAMAGES, COSTS OR EXPENSES OF ANY KIND GROWING OUT OF OR RELATED TO ANY SUCH ACTIVITIES IN WHICH THE MINOR PARTICIPATES. I UNDERSTAND THAT THIS IS A FULL AND COMPLETE RELEASE OF ALL INJURIES AND DAMAGES WHICH I OR THE MINOR MAY SUSTAIN AS A RESULT OF HIS OR HER PARTICIPATION IN ANY OF THE ACTIVITIES, REGARDLESS OF THE SPECIFIC CAUSE THEREOF.

I further acknowledge and agree that I have given my consent for the minor to participate in the Activities and to remain in the custody of King Road MB Church representatives while participating in the Activities.

This agreement is binding on all minor’s heirs, successors and personal representatives.

Dated: _____

Signed: _____ Parent/Guardian

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MEDICAL TREATMENT AUTHORIZATION AND POWER OF ATTORNEY

In the event the minor suffers an injury or condition during his or her participation in the Activities, including transportation to and from the Activity, which may endanger his or her life, cause disfigurement, physical impairment, or undue discomfort if medical treatment is delayed, and reasonable attempts to contact me have been unsuccessful, I hereby appoint eligible members of King Road MB Church leadership team as my agent(s) to act for me and in my name (in any way I could act in person) to make any and all decisions for the minor concerning his or her personal care, medical treatment, hospitalization and health care. This power of attorney and delegation of authority shall terminate when the agent is first able to contact me.

1. Minor's name: _____ Age: ____ Medical #: _____

Special medical allergies, chronic illness or other conditions:

2. Minor's name: _____ Age: ____ Medical #: _____

Special medical allergies, chronic illness or other conditions:

3. Minor's name: _____ Age: ____ Medical #: _____

Special medical allergies, chronic illness or other conditions:

4. Minor's name: _____ Age: ____ Medical #: _____

Special medical allergies, chronic illness or other conditions:

Family Doctor: _____ Doctor's phone: _____

Dated: _____ Signed: _____ (parent/guardian)