ADULT RELEASE OF LIABILITY AND MEDICAL INFORMATION

Diocese of Saint Augustine

I, _____, hereby acknowledge that on _____, 20__, I am scheduled to take a trip to _____ arranged by and through _____. I, _____, in the event of an emergency, hereby give permission to be transported to a hospital for emergency medical, dental, anesthetic or surgical treatment. I agree to pay for any expenses incurred for such treatment.

I release, indemnify, and hold harmless the Bishop of Saint Augustine or any parish thereof, its employees, agents, representatives, affiliates, and volunteers from any and all demands, claims, injury, and liability arising out of my participation in the program.

I hereby waive my claim to a lawsuit against the Diocese of Saint Augustine or any such persons for any liability arising out of my participation in this activity.

_____ _____

Signature Date

MEDICAL INFORMATION FORM

Name: _____Birth Date: _____

Address: _____

City: _____ State: _____Zip Code: _____

Home Phone Number: (___)_____In case of emergency notify: _____

Phone: __(___)_____ Relationship: _____

Name of Family Doctor: _____Tel. No.: _____

Do you have Insurance? Yes or No Company: _____(Attach copy of insurance card)

Policy No.: _____ Are you taking any Medication? Yes or No

If yes, Type/Name: _____ Dosage: _____

Do you currently have a medical problem or condition? Yes or No If yes, explain kind and symptoms_____

Please list allergies _____

When did you last have a tetanus shot? _____