

ADULT LIABILITY WAIVER

In addition to the Medical Information and Consent form, each adult participant, including group leaders and chaperons, must sign this form.

RELEASE OF LIABILITY

I, _____, agree on behalf of myself, my heirs, assigns,
Full Name

_____ executors, and personal representatives, to hold harmless and defend _____ Parish, the Archdiocese of New Orleans, its officers, directors, agents, employees, or representatives associated with the activity listed below from any and all liability claims, loss or damage arising from or in connection with my participation in the activity listed below.

Type of event: _____

Destination of event: _____

Sponsoring Agency: _____

Estimated time of departure and return: _____

Mode of transportation to and from event: _____

Signature

Date

Print Name

ADULT MEDICAL INFORMATION AND CONSENT FORM

GENERAL INSTRUCTIONS:

1. Please take care in filling out this form. It provides crucial information for caregivers in the event of illness or medical emergency. Accuracy and thoroughness are encouraged.
2. Sections I, II and V are mandatory. Sections III and IV provide you with treatment options in non-emergency situations.

Participant's name: _____

Birth date: _____ Sex: _____

Home address: _____
(Street) (City/State) (Zip)

Home phone: _____ Cellular phone: _____

Business phone: _____ Other: _____

SECTION I. MEDICAL MATTERS

I hereby authorize _____ or his/her assistants to carry out the
(Name of Adult Coordinator)
wishes I have named (herein) in areas of emergency medical treatment and other cases of illness. This authorization
inclusively extends from _____, 200 through _____, 200
(Date) (Date)

I hereby warrant that, to the best of my knowledge, I am in good health, and I assume all responsibility for my
health care.

Signature: _____ Today's Date: _____

**SECTION II. EMERGENCY MEDICAL
TREATMENT**

In the event of an emergency, I hereby give permission to be transported to a hospital for emergency medical or surgical
treatment. In the event of an emergency contact:

Name & relationship: _____

Phone: _____ Family doctor: _____ Phone: _____

Family Health Plan Carrier: _____ Policy #: _____

Signature: _____ Date: _____

(Over)

SECTION III: MEDICATIONS

I understand that I am responsible for taking my own medications and that such medications will be kept in well-labeled containers. Names of medications and concise directions for such medications, including dosage and frequency of dosage, are as follows:

Signature: _____ Date: _____

SECTION V: MEDICAL INFORMATION

The parish/group coordinator will take reasonable care to see that the following information will be held in confidence.

Allergic reactions (medications, foods, plants, insects, etc.): _____

Immunizations: Date of last tetanus/diphtheria immunization: _____

Do you have a medically prescribed diet? _____

Any physical limitations? _____

Are you subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bed-wetting, fainting?

Have you recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc? If

so, date and disease or condition: _____

I have the following special medical condition that you should be aware of: _____
