

**DIOCESE OF ALLENTOWN**

**ADULT PARTICIPATION FORM & RELEASE**

Participant's name: \_\_\_\_\_  
Birth date: \_\_\_\_\_ Sex: \_\_\_\_\_  
Home address: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Business phone: \_\_\_\_\_

I, \_\_\_\_\_, agree and understand that I assume the risks inherent in the field trip, and with full knowledge of the risks, I, and my heirs, successors and assigns, agree to release and to hold harmless and defend \_\_\_\_\_, and the Diocese of Allentown,  
(Name of parish/school)  
Bishop John O. Barres, D.D., S.T.D., J.C.L., and all of their employees and representatives, including chaperones, volunteers or any other representatives associated with the trip (all of whom are collectively referred to as the Diocese) from claims from or related to my participation, or in connection with any illness or injury (including death) or cost of medical treatment in connection therewith, and I agree to compensate the Diocese for reasonable attorney's fees and expenses incurred by the Diocese in any action brought against the Diocese as a result of such injury or damage, unless such claim arises from the negligence of the Diocese.

Description of trip:  
Type of event:  
Destination of event:  
Estimated time of departure and return:  
Travel information (airline, flight numbers, bus or train information):

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

**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: \_\_\_\_\_

**Medical Insurance Information:**  
Health Plan Carrier: \_\_\_\_\_  
Policy #: \_\_\_\_\_  
I.D. #: \_\_\_\_\_

**Specific Medical Information:** The parish/school should be aware of the following medical conditions. (The parish/school will take reasonable care to see that the following information will be held in confidence.)  
Allergic reactions (medications, foods, plants, insects, etc.): \_\_\_\_\_  
Physical limitations or other special medical conditions: \_\_\_\_\_

I have read carefully this entire (page 1) Adult Participation Form and Release and agree to its terms and intend to be bound hereby.

Participant's signature: \_\_\_\_\_ Date: \_\_\_\_\_