PAX Christi at St. Joseph Church, York, PA – **NOVEMBER 8, 2025**

LIABILITY/MEDICAL RELEASE FORM – ADULT PARTICIPANT

ONE FORM MUST BE COMPLETED FOR EACH *ADULT* ATTENDING!

Participant's Name_____ Birth Date_____

Cell#_____ E-mail_____

Group Name_____ City/State_____

Group Leader's Name_____

ADULT PARTICIPANT

I,_____(name), am attending PAX Christi to be held on November 8, 2025 at St. Joseph Church in York, PA. If needed for health reasons, I give permission for myself to be evaluated, diagnosed, treated and/or given medication in accordance with standard medical practice by licensed medical personnel. I relieve St. Joseph Roman Catholic Church of all responsibility and consequences that may arise as a result of this treatment. I will not hold St. Joseph Roman Catholic Church liable in the event of injury. Further, I agree to accept any and all financial responsibility as a result of scheduling medical treatment.

I agree to abide by all rules and regulations stated by St. Joseph Church and the PAX Christi staff. I understand that St. Joseph Roman Catholic Church will not be held liable if I fail to cooperate with regulations, and that any infraction of the rules may result in immediate dismissal from the event at my expense. **I also attest that I am in compliance with the Youth Protection Policies in my home diocese to be a chaperone for a youth event.**

I give permission to St. Joseph Church to photograph, videotape and/or film myself and to use my image in photographs, video, and/or film for the purpose of promoting the mission, activities and programs of PAX Christi. I understand that specific names of any individual participant will not be mentioned with any photos used for these stated purposes. I understand that I am not entitled to any compensation or rights in these materials, and I release St. Joseph Church from any liability for the use of my image for the above stated purposes.

SIGNATURE OF ADULT PARTICIPANT_____ **Date**_____

Family Physician_____ Phone#_____

Allergies (be specific)_____

Current Medications_____

Medical History (be specific)_____

Medical Insurance Provider_____ Insurance #_____

In case of emergency, please contact:

Name_____ Name_____

Phone#: Home_____ Phone#: Home_____

Cell_____ Cell_____