

HOLY FAMILY OF JOSEPH, MARY AND JESUS PARISH
DIocese OF VICTORIA IN TEXAS – FOR MEN'S ACTS TEAM
ADULT PERMISSION FORM/MEDICAL RELEASE

NAME _____ Gender: M or F Age _____
Address _____ City _____
St/Zip _____ Phone (____) _____
Birthdate _____ Parish/City _____

I would like to participate as a team member for an ACTS retreat, sponsored by **Holy Family of J.M.J. Parish** of the Diocese of Victoria in Texas from October 23rd-October 26th. I agree to defend, indemnify and hold harmless the Diocese of Victoria, its' clergy, officers, agents, employees and volunteers from any claims, costs or expenses for property damages, personal injuries or other damages arising out of my participation in the above mentioned activity. In case of an emergency, I grant permission and authorization for a designated adult representative of the ACTS Team to sign for treatment by a local physician and/or hospital selected by an adult representative of **Holy Family of J.M.J.** of the Diocese of Victoria in Texas.

_____ I agreed that I will **NOT** take pictures or videos during the retreat, and I also am aware that no firearms
Please initial or alcohol are allowed on the retreat grounds.

Date _____ Signature _____

Family Physician _____ Phone (____) _____

Address _____ City/Zip _____

1. Are you allergic to any type of medication? If so, please indicate: _____

Describe reaction? _____

2. Are you presently taking any prescription medication over an extended period of time? _____

Name of medication: _____ What is it for? _____

3. Do you have any allergies? _____ If so, what are they? _____

Last immunization/booster for Diphtheria/Tetanus: _____

Name of Insurance Company _____ Phone (____) _____

Address _____ City/St/Zip _____

Name of Insured _____ Policy or Group Plan # _____

_____ I do not have insurance.

In an emergency, if unable to reach parent/guardian, please contact:

Name _____ Work Phone (____) _____ Home Phone (____) _____

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