

St. Joseph Catholic Community
8701 36th Ave. N New Hope, MN 55427

Phone: 763-544-3352 ext 138

EFC 2024 Adult Leader Liability Waiver

ADULT LIABILITY WAIVER Each adult participant, volunteer, driver, group leader and chaperone, must sign this form.

Registration for Extreme Team and Prayer Team

Training Day: Saturday, May 11, 2024 9 am to Noon

Date of Camp: July 21-26, 2024

Location: Trinity Woods Camp and Retreat Center Trego, WI

Group Leaders: Larry Thomas

RELEASE OF LIABILITY, INDEMNIFICATION AGREEMENT & MEDICAL RELEASE

Print full name: _____

By placing your name here you agree on behalf of yourself, your heirs, assigns, executors, and personal representatives, to hold harmless, and defend Mary, Mother of the Church, St Michael's, St John the Baptist, St Mary of Lake, Pax Chrsi, St Joseph, St Edwards, Risen Savior, Sts Joaquim and Anne and St Gregory the Great., the Archdiocese of Saint Paul and Minneapolis, its officers, directors, agents, employees and representatives ('Releasees') associated with the Activity from any all liability claims, injury, loss and damage arising from or in connection with my participation in the Activity.

Further, I AGREE to hold Releasees harmless and indemnify Releasees for any claim or cause of action whatsoever arising out of the above Activity which takes place during the above identified dates that is brought against Releasees by myself or my family members, heirs, assigns, executors and personal representatives.

I UNDERSTAND that participation in the described activity involves danger and risk of injury. The inherent danger is understood and voluntarily assumed.

EMERGENCY MEDICAL TREATMENT: In the event that I should require medical treatment and I am not able to communicate my desires to attending physicians or other medical personnel, I give permission for the necessary emergency treatment to be administered. Please advise the doctors that I have the following allergies and/or other health conditions:

In case of an emergency and for permission for treatment beyond emergency procedures, contact:

Name of Emergency Contact: _____

Relation to me: _____

Emergency Contact Cell Phone: _____

Health insurance Carrier and ID Number: _____

Health Insurance Policy Number: _____

I HAVE READ THIS DOCUMENT. I UNDERSTAND IT IS A RELEASE OF ALL CLAIMS. I UNDERSTAND I ASSUME ALL RISK INHERENT IN THIS ACTIVITY. I VOLUNTARILY SIGN MY NAME EVIDENCING MY ACCEPTANCE OF THESE PROVISIONS.

By signing my Electronic Signature below, I acknowledge and agree this Electronic signature is the legally binding equivalent to my handwritten signature. The electronic signature has the same validity and meaning as my handwritten signature.

By placing my Electronic signature below I acknowledge and agree to the conditions above.

Signature _____ Date _____