ADULT GENERAL AND MEDICAL RELEASE FORM

Reason for which this release is intended: **Diocese of Kalamazoo Confirmation Retreat 2/17/2024**

Statement of Consent and Medical Release

In consideration of my being allowed to participate in the **Diocese of Kalamazoo Confirmation Retreat**, I hereby agree to release _____ Parish, the Roman Catholic Diocese of Kalamazoo, and any and all affiliated organizations, their employees, agents, representatives and volunteers, including volunteer drivers (collectively "Releasees"), from any and all claims, including negligence, which may be asserted by me arising from or relating to my participation in this diocesan youth gathering. In the event this release on behalf of myself is held to be invalid or unenforceable, I hereby agree to indemnify and hold harmless Releasees from any and all claims, including negligence, which may be asserted by me arising from or relating to my participation in this event. This release or indemnification does not apply to claims for intentional misconduct or gross negligence; nor does this release or indemnification apply to the extent of commercial insurance coverage for any claim; but this Release or Indemnification shall apply to the extent of any self-insurance or deductible applicable to any claim.

I do hereby authorize treatment by a qualified and licensed physician of any condition which, in the opinion of the physician, is deemed necessary and appropriate. I understand that reasonable attempts will be made as soon as possible to contact one of my emergency contact persons at the phone numbers listed in connection with any accident or emergency medical care. I understand that I retain all responsibility for costs associated with my medical care.

Name: _____ Date of Birth_____

Home Address: _____ City: _____

Home Phone: _____

List allergies, medication, contacts, or other pertinent comments:_____

_____

_____

Family Physician:_____ Physician Phone: _____

Physician Address: _____ City: _____

Emergency Contact Name and Telephone Number:

Name:_____ Daytime Phone: _____

Evening Phone: _____ Cell Phone: _____

*If the person listed above is unavailable, alternate emergency contact person and phone n*umber:

Name: _____ Daytime Phone: _____

Evening Phone: _____Cell Phone: _____

Health Insurance Data:

Company: _____ Policy #: _____

Group #: _____ Contract #: _____

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment deemed necessary and appropriate by the treating physician.

I fully understand and agree to the above terms and sign this form knowingly, willingly and freely.

_____ _____

Signature of Participant Date

Please return this entire form to your parish group leader.