CATHOLIC DIOCESE OF KALAMAZOO

ADULT GENERAL AND MEDICAL RELEASE FORM

Reason for which this release is intended: _____

STATEMENT OF CONSENT AND MEDICAL RELEASE

In consideration of my being allowed to participate in _____, 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/State Zip: _____
Primary Phone: _____ Secondary Phone: _____

List allergies, medication, contacts, or other pertinent comments (attach a second sheet if necessary): _____
_____

Family Physician: _____ Physician Phone: _____
Physician Address: _____ City: _____

Emergency Contact Information:
Name: _____ Relationship: _____
Primary Phone: _____ Secondary Phone: _____
*If the person listed above is unavailable, alternate emergency contact person and phone n*umber:
Name: _____ Relationship: _____
Primary Phone: _____ Secondary 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. By entering into and/or signing this document, the signatory/signatories agree to conduct its/their dealings via electronic means. The signatory agrees that allowing dealings via electronic means will facilitate these dealings. The signatory has the option to opt to sign things in a paper format. **I fully understand and agree to the above terms and sign this form knowingly, willingly and freely.**

Name of Participant_____

Signature of Participant _____ Date _____

Please return this completed form to your parish group leader.