Diocese of Superior

Adult Liability Waiver and Health Information

Please return this form to the appropriate parish/school/diocesan personnel by the date indicated below.

Your full legal name:_____

Date of birth: _____ **Gender:**_____

Address: _____

Phone numbers - Home: _____ **Work:** _____ **Cell:**_____

The individual identified above is eligible to be a chaperone or adult participant for the parish/school/ Diocese of Superior (DOS) activity described below. This activity will take place under the guidance and supervision of employees and/or volunteers from:_____

Type of activity: _____

Description of activity: _____

Date and time of activity: _____

Method of transportation: _____

Cost: _____

To participate in this activity, this completed and signed form must be returned to:

_____ no later than _____.

As per the Diocese of Superior Safe Environment Policies and in accordance with the United States Conference of Catholic Bishops' *Charter for the Protection of Children and Young People*, I have completed all of the appropriate documentation, as well as a background check and sexual abuse awareness and prevention training as apply to my particular participation in the above named activity. I agree to act in accordance with all other diocesan codes of conduct, guidelines and policies. I fully understand my responsibilities for this event as described to me by parish/school/DOS staff and or those planning the activity. I further agree on behalf of myself, my heirs, assigns, executors, and personal representatives, to hold harmless and defend (Parish Name)_____ , the Diocese of Superior, its officers, directors, agents, employees, or representatives associated with the field trip or event from any and all liability claims, loss or damage arising from or in connection with my participation in this activity.

Adult Participant Signature: _____ Date: _____

This is a two-sided form. Please complete both sides.

Emergency and Incidental Medical Treatment

In the event of an emergency, if I am rendered unconscious or cannot speak or make a decision for myself, please contact:

Name: _____ Relationship: _____

Phone numbers - Home: _____ Work: _____ Cell: _____

I understand that if the emergency contact that I have listed above cannot be reached, the parish/school/ DOS reserves the right to make a temporary decision that is in my best interest until such a time when I can answer for myself or my emergency contact can be reached.

Please supply all of the information requested below:

Health Insurance Company: _____

Policy # : _____

Physician or clinic: _____

Address:_____

_____

Phone: _____

Family dentist: _____

Address: _____

Phone: _____

Date of most recent physical examination: _____

Current medications: _____

_____

Dosage & frequency: _____

_____

Date of most recent tetanus immunization: _____

Known allergies: _____

Treatment for allergies: _____

Recent surgeries or serious illness: _____

Any other special needs to be noted: _____

I verify that all of the medical information above is correct and current to the best of my knowledge at the time of the activity described above. I have indicated all potential health issue for myself, including medications and any special dietary needs.

Adult Participant Signature: _____ Date: _____