St. Ambrose Catholic Church
4212 Mangum Rd.
Houston, TX 77092
713-686-5715

ADULT

MEDICAL RELEASE & LIABILITY FORM

TO BE FILLED OUT FOR ADULTS OVER THE AGE OF 18 WHO HAVE COMPLETED HIGH SCHOOL
PLEASE PRINT CLEARLY

Office use only
Cash/Check #: __________
Amount: $__________
Balance due: $__________
Received by: __________

Event Fee
$______

Event:______________________________ **Date(s):**______________________

Time(s):__________________ **Location(s):**___________________________

Name: __________________________ **Date of Birth:**____/____/____ **Age:**____ **Gender:** __Male __Female

Home Address: _____________________________ **City/State/Zip:**_____________________________

Phone:(____)____-______ **Can You Receive Texts?:** __Yes __No

E-mail:______________________________
Used only to send event info.

Emergency Contact :____________________ **Phone:**(____)____-______ **Relationship:**_____________________

Shirt Size (If Applicable, Circle one): Small Medium Large X-Large XX-Large XXX-Large

Do you have any allergy/dietary/physical restrictions?:____
____

Do you currently take any medications?
Please be sure the medications are well labeled with concise administering directions:_________________________
____

I **(mark one)** __**DO** __**DO NOT** carry medical insurance at this time.

Insurance Carrier:_______________________ **Policy Holder:**_________________________

Policy Number:____

Doctor's Name:_________________________ **Doctor's Number:**(____)____-______

BY SIGNING BELOW: I ALLOW PHOTOGRAPHS TAKEN OF ME TO BE USED AS PROMOTIONAL MATERIALS (FLYERS, WEB PAGE, NEWSLETTERS, ETC.) I AGREE TO HOLD HARMLESS AND DEFEND THE DIOCESE OF GALVESTON-HOUSTON, ST. AMBROSE CATHOLIC CHURCH (IT'S PASTOR, YOUTH MINISTER(S), OTHER AGENTS, ETC.) OR ANY REPRESENTATIVES ASSOCIATED WITH THE SCHEDULED ACTIVITY UNLESS THE PARTIES INVOLVED WERE CARELESS AND/OR NEGLIGENT. I WAIVE SUCH CLAIMS AGAINST SUCH ORGANIZATION OR ANY SUCH PERSON, ARISING DIRECTLY OR INDIRECTLY FROM OR ATTRIBUTABLE IN ANY LEAGAL WAY, TO ANY ACTION OR OMISSION TO ACT OF ANY SUCH ORGANIZATION OR PERSON IN CONNECTION WITH EXECUTION OF THEIS EVENT. I HEREBY WARRANT TO THE BEST OF MY KNOWLEDGE, I AM IN GOOD HEALTH, AND I ASSUME ALL RESPONSIBILITY FOR MY HEALTH. IN THE EVENT I DO NOT HAVE INSURANCE, PAYMENT IN FULL FOR MEDICAL CARE BECOMES THE RESPONSIBLILITY OF MYSELF. IN THE EVENT OF AN EMERGENCY, I HEREBY GIVE PERMISSION TO BE TRANSPORTED TO A HOSPITAL FOR EMERGENCY MEDICAL OR SURGICAL TREATMENT. I WISH TO BE ADVISED PRIOR TO ANY FURTHER TREATMENT BY THE HOSPITAL OR DOCTOR. I CERTIFY THAT ALL INFORMATION CONTAINED HEREIN IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I AGREE TO ABIDE BY ANY/ALL POLICIES AND RULES ESTABLISHED FOR THIS EVENT/ACTIVITY (SEE CODE OF CONDUCT.) SHOULD I NOT BE ABLE TO MAINTAIN THE GUIDELINES AND EXPECTATION OF THE ADULT CHAPERONES/YOUNG ADULT ASSISTANTS, I UNDERSTAND THAT THERE WILL BE CONSEQUENCES FOR MY ACTIONS, WHICH COULD INCLUDE BEING ASKED TO LEAVE THE EVENT AT MY EXPENSE.

_______________________________ **SIGNATURE**

_______________________________ **TODAY'S DATE**