

# DIOCESE OF BOISE ADULT MEDICAL RELEASE & LIABILITY FORM

Event: \_\_\_\_\_ DATE: \_\_\_\_\_

NAME OF ADULT \_\_\_\_\_

I agree that in the event I am injured as a result of my participation in the above named activity, including transportation to and from this activity, whether or not caused by the negligence (active or passive) of the parish/school or diocesan youth activity program, or any of its agents or employees, recourse for the payment of any resulting hospital, medical, or related costs will first be paid by my insurance or any available benefit plan of mine.

**I am not aware of any medical condition I have, which would render it inappropriate for me to participate in any activity.**

I, hereby, give permission to the medical personnel selected by the youth activity supervisory personnel present, should I not be conscious for permission or consultation, to render medical treatment deemed necessary and appropriate by the physician, R.N. or dentist.

Participants are advised that photographs or videotape of participants may be used in publications, websites or other materials produced periodically by Diocese of Boise, Office of Catechesis or local parishes. (Participants would not be identified without specific written consent. Adults who do not wish to be photographed or filmed should so notify the parish/Diocesan Office of Catechesis in writing. Please note that the Office of Catechesis has no control over the use of photographs or film taken by media that may be covering the event in which you participate.

I understand that during the activity I may be transported to and from the activity site via a personal vehicle and/or van.

Date \_\_\_\_\_ Signature \_\_\_\_\_

## MEDICAL HISTORY FOR ANY HOSPITAL OR PRACTITIONER

Allergies/Food Restrictions \_\_\_\_\_

Medication being taken (name & dosage) \_\_\_\_\_

Date of last tetanus shot \_\_\_\_\_

Physical Impairments/Limitations \_\_\_\_\_

Other health issues the Physician should be aware of \_\_\_\_\_

Please check if this applies.

I am covered by hospitalization and medical insurance under policy #: \_\_\_\_\_

issued by \_\_\_\_\_.

The subscriber's name is \_\_\_\_\_. The family physician is \_\_\_\_\_

and he/she can be reached at # \_\_\_\_\_.

Emergency Contact Information

Emergency Contact Name \_\_\_\_\_ Home Phone Number \_\_\_\_\_

Cell Phone Number \_\_\_\_\_ Work Number \_\_\_\_\_

—This form should be kept on file by the parish Coordinator of Youth Ministry./ Esta forma debe permanecer archivada por el Coordinador de Pastoral Juvenil Parroquial.—