Marycrest Youth Day – Adult Registration Form – Chaperones & Volunteers

Adult Medical Information and Liability Waiver

Each adult participant: group leader, chaperone, and volunteer must sign this form.

Name _____ Cell: _____
Address_____
T-shirt size _____Email: _____
Parish/School _____ Parish/School City _____

Initial here _____ if you <u>do NOT give permission</u> for photographs or video recordings of you taken during the course of this event that their image may be used in either print, electronic, or video form for promoting youth ministry or the mission of the *Parish Visitors of Mary Immaculate*.

Release of Liability/Medical Release

I, _____ (full name), agree on behalf of myself, my heirs, assigns, executors and personal representatives, to hold harmless and defend _____ (name of parish/school), its officers, directors, employees and agents, the *Parish Visitors of Mary Immaculate*, its employees and agents, chaperones or representatives associated with the event, from any claim arising from or in connection with my attending the event or in connection with any illness or injury (including death) or cost of medical treatment in connection therewith, and I agree to compensate the parish/school, its officers, directors and agents, and the *Parish Visitors of Mary Immaculate*, its employees, agents, chaperones or representatives associated with the event for reasonable attorney's fees and expenses which may incur in any action brought against them as a result of such injury or damage, unless such claim arises from the negligence of the parish/school/*Parish Visitors of Mary Immaculate*.

I know and will uphold the Safe Environment policies and practices of the Archdiocese of New York.

As a representative of the Catholic Church, I understand that I am expected to be a role model for the youth attending this event.

In the event that I should require medical treatment and I am not able to communicate my desires to attending physicians or other medical personnel, I give permission for the necessary emergency treatment to be administered. Please advise the doctors of the following:

Allergies: _____
_____
(Optional) Medical conditions: _____
_____
_____
(Optional) Medications: _____
_____
_____

In case of an emergency and for permission for treatment beyond emergency procedures, please contact:
Name:_____ Relationship to me: _____
Daytime phone: ( ) _____ Evening phone: ( ) _____
Health insurance carrier: _____
Insurance ID number: _____ Insurance policy number: _____

Signature: _____ Print name: _____ Date: _____