

Holy Week Mission
2018
March 28th - 31st

**DIOCESE OF ALLENTOWN
ADULT PARTICIPATION FORM & RELEASE**

Participant's name: _____
Birth date: _____ Sex: _____
Home address: _____
Home phone: _____ Business phone: _____

I, _____, agree and understand that I assume the risks inherent in the field trip, and with full knowledge of the risks, I, and my heirs, successors and assigns, agree to release and to hold harmless and defend St. Columbkille, and the Diocese of Allentown, (Name of parish/school)
The Apostolic Administrator, and all of their employees and representatives, including chaperones, volunteers or any other representatives associated with the trip (all of whom are collectively referred to as the Diocese) from claims from or related to my participation, or in connection with any illness or injury (including death) or cost of medical treatment in connection therewith, and I agree to compensate the Diocese for reasonable attorney's fees and expenses incurred by the Diocese in any action brought against the Diocese as a result of such injury or damage, unless such claim arises from the negligence of the Diocese.

Description of trip:
Type of event: Holy Week Mission 2018
Destination of event: St. Columbkille Parish and Surrounding areas/churches
Date and Estimated time of departure and return: March 28th - 31st, 2018
Travel information (airline, flight numbers, bus or train information): Bus for visitation of churches

Medical Matters: I hereby warrant that to the best of my knowledge, I am in good health, and I assume all responsibility for my health.

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to be transported to a hospital for emergency medical or surgical treatment. In the event of an emergency contact:

Name & relationship: _____ Phone: _____
Family doctor: _____ Phone: _____

Medical Insurance Information:

Health Plan Carrier: _____
Policy #: _____
I.D. #: _____

Specific Medical Information: The parish/school should be aware of the following medical conditions. (The parish/school will take reasonable care to see that the following information will be held in confidence.)
Allergic reactions (medications, foods, plants, insects, etc.): _____

Physical limitations or other special medical conditions: _____

I have read carefully this entire Adult Participation Form and Release and agree to its terms and intend to be bound hereby.

Participant's signature: _____ Date: _____