

**ST. CHARLES BORROMEO CATHOLIC CHURCH  
ADULT LIABILITY WAIVER**

**RELEASE OF LIABILITY**

I, \_\_\_\_\_, agree on behalf of myself, my heirs, assigns, executors, and personal representatives, to hold harmless and defend St. Charles Borromeo Parish, the Archdiocese of New Orleans, its officers, directors, agents, employees, or representatives associated with the activity listed below from any and all liability claims, loss or damage arising from or in connection with my participation in the activity listed below:

**Type of event:** World Youth Day New Orleans

**Destination of event:** Morial Convention Center

**Date of Event:** October 22, 2017

**Mode of transportation to and from event:** Jefferson Parish School Bus

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

**Print Name** \_\_\_\_\_

# ST. CHARLES BORROMEIO CATHOLIC CHURCH ADULT MEDICAL INFORMATION AND CONSENT FORM

Participant's name \_\_\_\_\_

Address \_\_\_\_\_

Birth Date \_\_\_\_\_ Sex \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Business Phone # \_\_\_\_\_ Other Phone # \_\_\_\_\_

## SECTION I. MEDICAL MATTERS

I hereby authorize St. Charles Borromeo Parish to carry out the wishes I have named (herein) in areas of emergency medical treatment and other cases of illness. I hereby warrant to that, to the best of my knowledge, I am in good health, and I assume all responsibility for my health care.

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

## SECTION II. 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: \_\_\_\_\_  
Family Health Plan Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## SECTION III. MEDICATIONS

I understand that I am responsible for taking my own medications and that such medications will be kept in well-labeled containers. Names of medications and concise directions for such medications, including dosage and frequency of dosage, are as follows: \_\_\_\_\_  
\_\_\_\_\_

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

## SECTION IV. MEDICAL INFORMATION

The parish coordinator will take reasonable care to see that the following information is held in confidence.

Allergic reactions (medications, foods, plants, insects, etc.): \_\_\_\_\_

Immunizations: Date of last tetanus/diphtheria immunization: \_\_\_\_\_

Do you have a medically prescribed diet? \_\_\_\_\_

Any physical limitations? \_\_\_\_\_

Are you subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bed-wetting, fainting? \_\_\_\_\_

Have you recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc? If so, date and disease or condition: \_\_\_\_\_

I have the following special medical condition that you should be aware of: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_