ARCHDIOCESE OF NEW ORLEANS
ADULT LIABILITY WAIVER

In addition to the Medical Information and Consent form, each adult participant, including group leaders and chaperons, must sign this form.

RELEASE OF LIABILITY

I, ______________________________, agree on behalf of myself, my heirs, assigns, executors, and personal representatives, to defend, hold harmless, and indemnify _____________________ Parish/School, and The Roman Catholic Church of the Archdiocese of New Orleans, their members, directors, officers, agents, employees, or representatives from any and all liability claims, loss, or damage arising from my negligent and/or intentional acts during my participation in the event described below.

Type of event: ____

Destination of event: ____

Sponsoring Agent: ____

Estimated time of departure and return: ____

Mode of transportation to and from event: ____

__________________________________   ________________________
Signature   Date

____
Print Name

ADULT MEDICAL INFORMATION AND CONSENT FORM

GENERAL INSTRUCTIONS:

1. Please take care in filling out this form. It provides crucial information for caregivers in the event of illness or medical emergency. Accuracy and thoroughness are encouraged.
2. Sections I, II and V are mandatory. Sections III and IV provide you with treatment options in non-emergency situations.

SECTION I. PERSONAL INFORMATION

Participant's name: ___________________________
____

Birth date: ___________________________________ Gender: ______________________________

Home address: ____

(Street) (City/State) (Zip)

Home phone: ________________________________ Cellular phone: ____________________________

Business phone: ______________________________ Other: ______________________________________

SECTION II. MEDICAL MATTERS

I hereby authorize ____, or his/her assistants to carry out the

(Name of Adult Coordinator)

wishes I have named (herein) in areas of emergency medical treatment and other cases of illness. This authorization inclusively extends from _________________, 20____ through _________________, 20____.

(Date) (Date)

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

Signature: ____ Today's Date: ______________________

SECTION III. 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: _________________________

(Over)

SECTION IV: 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:

Medication: ________________________ Dosage: ______________ Frequency: ______________________

Medication: ________________________ Dosage: ______________ Frequency: ______________________

Medication: ________________________ Dosage: ______________ Frequency: ______________________

Medication: ________________________ Dosage: ______________ Frequency: ______________________

Signature: ____ Date: _________________________

SECTION V: MEDICAL INFORMATION

The parish/group coordinator will take reasonable care to see that the following information will be 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: ___________________________

____

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