Diocese of Paterson

HEALTH INFORMATION/RELEASE OF LIABILITY/CONSENT TO TREAT

I/we request that my/our son/daughter attend the _**ANTIOCH RETREAT** under the auspices of __**Our Lady of the Mountain** to be held at _**Hope Retreat Center**__ on _**4/25-4/26/2020**. I/we have read the foregoing Health Information /Release of Liability / Consent to Treat Form and the answers are all correct.

I/we can be reached at the telephone numbers referred to above but if emergency medical care of treatment shall be necessary and if I/we cannot be contacted, I/we authorize the delegated agents of **Our Lady of the Mountain** to act on my/our behalf and approve appropriate treatment.

Release of Liability: In consideration of **Our Lady of the Mountain** accepting my/our son's/daughter's registration for this event, I/we release, hold harmless and discharge **Our Lady of the Mountain,** its officers, Trustees, employees, agents and affiliates, as well as the Roman Catholic Diocese of Paterson and Bishop Arthur J. Serratelli, S.T.D., S.S.L., D.D. and or his successor, as well as any and all agents and /or employees of the Roman Catholic Diocese of Paterson from any and against all liability, claim, loss, damage, cost or expense including counsel fees remitting from any and all claims for bodily injury and /or property damage, and I we further waive any such claims against any such person or any such person or organization in connection with this event and I/we further agree to indemnify and hold harmless the parish and its aforesaid affiliated personnel from any such liability, claim, loss, damage, cost or expense as already set forth.

Date_____

Witness_____Parent or Guardian – indicate which and if Guardian, give details on back

Witness Address_____

Approve and sign off where applicable
Pastor if parish related _____
Principal if school related_____
Agency Director if agency_____

(**Continue over)**

Diocese of Paterson

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First Name_____Last Name_____

Address _____City/State/Zip_____

Name of
Parent(s)/Guardian(s) _____

Home Phone#_____Work Phone#_____ Cell Phone# _____

Health Insurance Company_____Policy#_____

Male/Female_____Age_____Birth Date_____Grade____Youth____Adult_____

Parish _____ Parish City_____

Are you currently under the care of a doctor, psychologist or psychiatrist? _____

Name of Family Physician _____Phone#_____

Last Tetanus shot_____

Allergies to Drugs/Foods_____ Please explain:

_____

_____

Do you have any special dietary needs or restrictions?

Special Medications, blood type or pertinent medical information:

_____

Witness_____ Applicant's Signature_____

Witness Address_____