DIOCESE OF ALLENTOWN
ADULT PARTICIPATION FORM & RELEASE

Participant's name:____
Birth date:____Sex:____________________________
Home address:____
Home phone:_____________________________ Business phone:__________________________________
E-mail:____

I, ___________________________, agree and understand that I assume the risks inherent in this trip, and with full knowledge of the risks, I, and my heirs, successors and assigns, agree to release and hold harmless and defend the _________________________Charitable Trust (school or parish name), The Diocese of Allentown, and its Bishop or Administrator, their respective charitable trusts, and the respective members, trustees, directors, officers, employees and representatives of those entities, including chaperones, volunteers or any other representatives associated with that activity (all of whom are separately and 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: ____
Destination of event: ____
Date and Estimated time of departure and return: ____
Travel information (airline, flight numbers, bus or train information): _______________________

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: __________________________________