

**Diocese of Worcester**  
**Adult Participation Form (for those 18 years of age and older)**

**RELEASE/INDEMNIFICATION/DEFENSE AGREEMENT**

I, \_\_\_\_\_, hereby irrevocably release from all liability to the fullest extent permitted by the law, and hereby agree to indemnify, defend and hold harmless the Roman Catholic Bishop of Worcester, a corporation sole, its officers, agents, representatives, volunteers, chaperones, clergy, religious and employees of the Diocese of Worcester and any and all parishes and ministries thereof (**collectively, "RCB"**), from and against any and all liability, demands, actions, causes of action, claims, judgments, cost and expense, including but not limited to attorneys' fees, known or unknown at this time, arising out of or in any way related to any injury, illness, loss or other damage to person or property incurred: (a) by myself while participating in or traveling to or from, or in any way arising out of, the following event or activity (***list event or activity and its location as well as date/s on line below***); June 2019-June 2020: **St. Bernard's Church of Our Lady of Providence Parish pertaining to the Athletic/Spiritual/Intellectual/Human development** and/or (b) by any other person sustaining or alleged to have sustained any injury, illness, loss or expense, including attorneys' fees, by reason of my negligent or wrongful act or omission.

The RCB's right to defense at my expense shall accrue immediately upon the utterance of any and all claims or complaints arising out of, based upon or in any way associated with the activity or event, regardless of other claims simultaneously brought, and shall not be contingent upon the merit of any such claim(s) or any question(s) of fact raised by the claim or complaint.

I agree to cooperate with and to follow the above-referenced event's or activity's rules and any instructions of the RCB. In the event I do not cooperate with or follow same I agree to withdraw immediately from the event or activity referenced above and to refrain from attending any further event or activity-related events, if so requested by RCB.

Additionally:

- In the event of my inability to do so on my own, and only for so long as my spouse or duly appointed health care agent is unavailable or unable to act or communicate on my behalf, I appoint RCB as my lawful attorney-in-fact, to act for me in my name and stead and on my behalf, in any way that I would, in the reasonable and sole judgment of RCB, be expected to act if I were not so incapacitated, with respect to the following matters if any injury, illness or medical emergency occurs during the activity:
- To give any and all consents and authorizations to any physician, dentist, hospital or other persons or institutions pertaining to any emergency medications, medical or dental treatments, diagnostic or surgical procedures or any other first aid and/or emergency actions as the RCB acting as my attorney-in-fact shall deem necessary or appropriate for my best interest.
- The release/indemnification/defense provisions above shall apply to any such decision or action.
- I understand that RCB through its agents will make a reasonable attempt to contact my spouse or duly appointed health care agent as soon as reasonably possible in the event of injury, illness or medical emergency involving me.
- The powers and authority granted herein may be revoked prospectively by written notice delivered in-hand to RCB, provided that in such notice I confirm that I am immediately assuming full responsibility for all decisions and actions as to my welfare and health and revoking this authorization. Absent receipt of such written notice this power of attorney shall not be affected by my disability, incapacity or adjudicated incompetence.
- This power of attorney shall lapse automatically upon completion of the event or activity I am participating in or attending and related activities, and travel if any. Any revocation, termination

or lapse of such powers and authority shall not affect any other provision of this Release/Indemnification/Defense Agreement, each of which shall continue in full force and effect.

- There are no medical conditions, nor any life threatening allergies to foods or medicines, that would limit my full participation in, or attendance at, as the case may be, the activity, nor require any special precautions except as I list here

\_\_\_\_\_

- List any current medications and dosage (prescription and over-the-counter) that the RCB might need to know about should an emergency arise here:

\_\_\_\_\_

- If any change occurs in the information which I have provided with respect to emergency contacts or medical information I shall provide immediate written notification of such change to the RCB.

As evidenced by my signature below, RCB and/or an agent thereof may use my portrait or photograph for promotional purposes related to the advancement and development of the ministry of the Roman Catholic Church and the Diocese of Worcester, and I hereby release, indemnify and agree to defend under the provisions above the RCB and its agents from any and all liability, loss, damage and expense, including attorneys' fees, resulting from such use.

**By signing below I verify that I have carefully read and understand this statement and that I am signing it freely and voluntarily in consideration of the RCB's agreement to allow me to participate in this voluntary activity, trip or event, and as an inducement to the RCB to permit such participation, without which it would not do so. I request that I be allowed to participate in the above-referenced activity, trip or event.**

Signature of participant \_\_\_\_\_

Date \_\_\_\_\_

**PLEASE PRINT THE FOLLOWING INFORMATION**

Name of person signing this form \_\_\_\_\_

Date of Birth \_\_\_\_\_

Complete Address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Participant's Home or Cell Phone \_\_\_\_\_

#1 Emergency Contact Name \_\_\_\_\_

Relationship \_\_\_\_\_

Emergency Contact Phone (Home or Cell) \_\_\_\_\_

Duly Appointed Health Care Agent Name *(if different from above and if any)* \_\_\_\_\_

Health Care Agent Home or Cell phone \_\_\_\_\_

Family Doctor: Name \_\_\_\_\_ Phone: \_\_\_\_\_

Health Insurance Provider \_\_\_\_\_

Membership Number \_\_\_\_\_

Parish/School and Town \_\_\_\_\_