



# Diocese of Fargo: Adult Liability Waiver

SEARCH Retreat || Sisters of Mary of the Presentation Convent

## General Information

Participant's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

I, \_\_\_\_\_, grant permission for my child listed above to participate in Diocese of \_\_\_\_\_  
(Parent/Guardian Name)

Fargo *SEARCH Retreat* which requires transportation to and from Sisters of Mary of the Presentation Convent, Valley City, ND. This activity will take place under the guidance and direction of diocesan employees and volunteers from parishes in the Diocese of Fargo. A brief description follows:

**Type of event:** Search Retreat

**Location of event:** Sisters of Mary of the Presentation Convent, Valley City, ND

**Individual(s) in charge:** Jim & Dori Picard - Directors of SEARCH and Brady Borslien Diocesan Youth Minister

**Date of event** (circle one): Nov. 6-8, 2020 Jan 15-17, 2021 Feb 26-28, 2021 April 16-18, 2021

**Cost for Event:** Team - \$50.00 New SEARCHer - \$60.00

## Liability Waiver

I HEREBY ASSUME ALL OF THE RISKS OF PARTICIPATING IN ANY/ALL ACTIVITIES ASSOCIATED WITH THIS EVENT, including by way of example and not limitation, any risks that may arise from negligence or carelessness on part of the persons or entities being released, from dangerous or property owned, maintained, or controlled by them, or because of their possible liability without fault. I acknowledge that this Accident Waiver and Release of Liability Form will be used by the Diocese of Fargo, its officers, directors and agents, chaperones, or representatives associated with the activity, and that it will govern my actions and responsibilities at said activity.

On my behalf and on the behalf of any heirs, executor and assigns, I hereby:

- (A) WAIVE, RELEASE, AND DISCHARGE from any and all liability, including but not limited to, liability arising from the negligence or fault of the entities or persons released, for my death, disability, personal injury, property damage, property theft, or actions of any kind which may hereafter occur to me, including my traveling to and from this activity, THE FOLLOWING ENTITIES OR PERSONS: The Diocese of Fargo, and/or their directors, officers, employees, volunteers, representatives, and agents, and the activity holders, sponsors, and volunteers;
- (B) INDEMNIFY, HOLD HARMLESS, AND PROMISE NOT TO SUE the aforementioned entities or persons from any and all liabilities or claims made as a result of participation in this activity, whether caused by the negligence of release or otherwise.

I acknowledge that The Diocese of Fargo and their directors, officers, volunteers, representatives, and agents are NOT responsible for the errors, omissions, acts, or failures to act of any party or entity conducting a specific activity on their behalf.

**I understand while participating in this activity, that I may be photographed. I agree to allow my photo, video, or film likeness to be used for any legitimate purpose by the activity holders, producers, sponsors, organizers, and assigns.**

This waiver shall be construed broadly to provide a release and waiver to the maximum extent permissible under applicable law. I CERTIFY THAT I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND ITS CONTENT. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND CONTRACT AND I SIGN IT OF MY OWN FREE WILL. BY SIGNING MY NAME BELOW, I AGREE TO THE ABOVE TERMS AND CONDITIONS.

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

## Medical Matters

The Diocese of Fargo will take reasonable care to see that the following information will be used only for its intended purpose shall not be released to a third party unless necessary for medical treatment.

### A. 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 where I am unable to make a decision please contact:

Name & Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Family doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Health Plan Carrier: \_\_\_\_\_ Policy: \_\_\_\_\_ Group: \_\_\_\_\_

### B. Medications:

\_\_\_\_\_ **Initial Here If:** I am taking medications at present: I will bring all such medications necessary, and such medications will be well labeled. Names of medications and concise directions, including dosage and frequency of dosage, are as follows: \_\_\_\_\_

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### C. Special Medical Information:

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

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

Does participant have a medically prescribed diet? \_\_\_\_\_

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

Has participant recently been exposed to contagious disease or conditions, such as mumps, measles, chicken pox, etc.? If so, date and disease or condition: \_\_\_\_\_

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You should be aware of these special medical: \_\_\_\_\_

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