ADULT MEDICAL RELEASE FORM

Date: _____

Print Name: _____

Parish: _____

Address: _____

City: _____State: _____ Zip Code: _____

Home Phone Number: (____)_____Work Phone Number: (_____)_____

Physician's Name: _____Phone # (____)_____

Date of Birth: _____ Date of last tetanus shot: _____

Please list **all** medical conditions/allergies/special health information: _____
_____
_____

Please list **any** medications (prescriptions or non-prescription) that you would like us to be aware of: _____
_____

Medical Insurance Company: _____ Policy Number: _____

Policy in the name of: _____Relationship: _____

Emergency Contact Name and Number: _____

In the event that the participant does not have insurance, payment in full for medical care becomes the responsibility of the patient.

I, _____, do hereby release, hold harmless and discharge the Diocese of Little Rock, its staff and volunteers from any and all liability, claim, loss, damage, cost or expense arising from my participation in this event. I waive such claims against such organization or any such person, arising directly or indirectly from or attributable in any legal way, to any action or omission to act of any such organization or person in connection with execution of this event. I authorize treatment by a licensed medial physician or licensed medical team in case of any accident or illness that may so arise, or any hospitalization necessary.

Signature: _____