



Archdiocese of Seattle

Adult Release of Liability / Medical Release

Each adult participant, including group leaders and chaperones, must sign this form

Participant's Name: _____

Home Address: _____

Home Phone: _____ Work Phone: _____

e-mail: _____

I, (Participant) _____, am eligible to participate in this organization-sponsored event that requires transportation to a location away from the organization site. This activity will take place under the guidance and direction of organization employees and/or volunteers from _____
(Name of Organization)

Description of Activity/Event:

Type of event: _____

Destination of event: _____

Dates of event: _____

Estimated time of departure: _____ Estimated time of return: _____

Mode of transportation to, from and during event: _____

Cost: _____

I (participant) _____, agree on behalf of myself, my heirs, successors, assigns, executors, and personal representatives, to hold harmless and defend (Organization) _____, its officers, directors and agents, and the Corporation of the Catholic Archbishop of Seattle, or representatives associated with the event from any and all actions, claims, demands, damages, costs, expenses and all consequential damage arising from or in connection with my attending the event or in connection with any illness or injury or cost of medical treatment in connection therewith, and I agree to compensate the organization, its officers, directors and agents, and the Corporation of the Catholic Archbishop of Seattle, or representatives associated with the event for reasonable attorney's fees and expenses arising therewith.

In the event that I should require medical treatment and I am not able to communicate my desires to attending physicians or other medical personnel, I give permission for the necessary emergency treatment to be administered.

Please advise the doctors that I have the following allergies:

In case of an emergency and for permission for treatment beyond emergency procedures, please contact:

Name: _____ Relationship to me: _____

Day Phone: _____ Evening Phone: _____

Health Insurance Carrier: _____ Policy Number: _____

Signature: _____ Date: _____