PAX CHRISTI CATHOLIC CHURCH FIELD TRIP

ADULT LIABILITY WAIVER & FIELD TRIP HEALTH INFORMATION/RELEASE FORM

I, _____, agree on behalf of myself, my heirs, assigns, executors, and

personal representatives, to hold harmless and defend Pax Christi Catholic Church and the Catholic Diocese of Lexington,

its officers, directors, agents, employees, or representatives associated with the field trip as described below.

Type of Event:	**Youth Group Lock-in**
Destination of Event:	**Pax Christi Catholic Church**
Individual in Charge:	**Naomi Schick**
Date of Event:	**September 9-10, 2016, 8 PM – 8 AM**
Estimated time of departure and return:	**Not leaving the church grounds**
Mode of Transportation to and from event:	**Not leaving the church grounds**

I agree on behalf of myself or my heirs, successors, and assigns, to hold harmless and defend **Pax Christi Catholic Church**, its officers, directors, and agents, and the **Catholic Diocese of Lexington**, chaperons, or representatives associated with the event, 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 parish, its officers, directors, and agents, and the **Catholic Diocese of Lexington**, chaperons, or representatives associated with the event for reasonable attorney's fees and expenses arising in connection herewith.

Signature: _____ Date:_____

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, I am in good health, and I assume all responsibility for my own health. (Of the following statements pertaining to medical matters, sign only those applicable.)

Emergency Medical Treatment: In the event of an emergency, if I am unable to make decisions for myself, I hereby give permission to transport me to a hospital for emergency medical or surgical treatment. My emergency contact should be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, contact:

Name & relationship:_____

Phone:_____ Family Doctor:_____ Phone:_____

Family Health Plan Carrier:_____ Policy #: _____

Signature:_____ Date: _____

Other Medical Treatment:

Medications: I am taking medication at present. I will bring all such medications necessary, and such medications will be well labeled. Names of medications and concise directions for such medications, including dosage and frequency of dosage, will be properly labeled:

_____

Signature:_____ Date: _____

No medication of any type, whether prescription or non-prescription, may be administered to me unless the situation is life threatening and emergency treatment is required.

Signature: _____ Date:_____

Specific Medical Information: The parish will take reasonable care to see that the following information will be held in confidence.

Allergic reactions (medications, foods, plants, insects, etc.) _____

Immunizations: Date of last tetanus/diphtheria immunization:_____

Does you have a medically prescribed diet? _____

Any physical limitations?_____

Have you recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc?_____

If so, date and disease or condition:_____

You should be aware of these special medical conditions: _____

_____

_____

_____

Signature:_____ Date: _____