

Adult Permission, Liability Waiver and Health Form

Diocese of Davenport

NCYC (National Catholic Youth Conference)

November 8-11, 2007, in Columbus, Ohio

Name: _____ Date of Birth _____ (mm/dd/yy)

Street Address _____

City, State and ZIP _____ Sex: M F

Are you in general good health and able to participate in general activities? Yes _____ No _____

If not, please indicate special circumstances and situations here: _____

Do you have allergies that we should be aware of? (optional) _____

Do you take medications that you'd like us to be aware of? (optional) _____

Name of family physician or clinic _____

Street Address _____ Phone _____

City, State, and ZIP _____

In signing this health form, I hereby certify that the above information is correct and give permission for the release of medical records to an attending physician in case of illness.

In case of medical emergency, I hereby give permission to the health care provider selected by the diocese or parish leaders to hospitalize and to secure proper diagnosis and treatment including but not limited to injection, anesthesia or surgery. I accept responsibility for all medical/surgical treatment charges which may be incurred. I hereby give permission to health officials to release medical information to the adult chaperone as needed for my health and safety.

During the NCYC, I give my permission to the Diocese of Davenport and the parish to take photographs and video of me to be used for future promotional items.

I request that I be allowed to participate in, and be transported to and from, the National Catholic Youth Conference, November 8-11, 2007 in Columbus, Ohio.. I hereby release and indemnify the Diocese of Davenport, its staff and volunteers and my parish, its staff and volunteers from any liability arising from claims of any kind or nature whatsoever from my participation in this program.

Signature _____ **Date** _____

Full address: _____
Street city state ZIP

Emergency contact: _____ Phone: _____

(Evening) _____ (Please be sure phone numbers are legible).

Second emergency contact: _____ Phone _____

Health Insurance Company _____

Health Insurance Policy # _____

A photocopy of the Primary Health Insurance card must be submitted with this form.