Diocese of Rochester **Participation Form (over 18)**

Participant Name: _____ **Event:** _____

Date of Birth: _____ **Sex:** _____

Street: _____ **City:** _____ **Zip:** _____

Home Phone: _____ **Emergency Phone:** _____

Emergency Contact: _____ **Relationship:** _____

Home Phone: _____ **Cell Phone:** _____

Health Insurance Co: _____ **Policy #:** _____

Primary Care Physician: _____ **Physician's Phone:** _____

Health History: Please list any medical conditions that might affect your participation in this program. Please include any medications currently taken by you on a regular basis.

Any allergies or special needs / concerns / dietary restrictions, health concerns:

_____

_____

Any medications (prescription and/or non-prescription) currently taking - including dosage:

_____

_____

Release Statement: I give permission to be transported in a privately owned vehicle or emergency transportation for medical emergencies only and for the release of medical records to an attending health care professional in case of injury or illness. I hereby give permission for a qualified physician to secure proper treatment.

I certify that I am in good health and have no limitations other than those I have listed, which may predispose me to risk during participation in the program.

I hereby release the Diocese of Rochester and all of its affiliated entities, including its employees, volunteers and parish sponsor from any and liability for any damages suffered as a result of or relating to my participation in the program liability.
I agree that neither the Diocese of Rochester or the parish sponsor will be responsible for reimbursement of copayments or uninsured medical costs.

Participant Signature _____ **Date:** _____