# ARCHDIOCESE OF GALVESTON-HOUSTON
# ADULT MEDICAL RELEASE FORM

I, ________________________________________, do hereby release, hold harmless and discharge the Archdiocese of Galveston-Houston, 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 medical physician or licensed medical team in case of any accident or illness that may so arise, or any hospitalization necessary.

Print Name:________________________________________ Date: ______________________________

Signature: ________________________________________

Address: ______________________________________________________________________________

City:_____________________________________________ Zip code: ___________________________

Parish: __________________________________________________________________________

Home Phone:_______________________________________ Work Phone: _________________________

Physician's Name:___________________________________ Home Phone: _________________________

Date of Birth:______________________________________

Date of last Tetanus shot: ____________________________

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

Please list **any** medications (prescription 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.