

**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.