OFFICE OF FAITH FORMATION
423 HIGHLAND AVE.
FALL RIVER, MASSACHUSETTS 02720
TEL: (508)678-2828 FAX: (508)675-3864

ADULT MEDICAL WAIVER, LIABILITY & PHOTO RELEASE AGREEMENT

I _____, choose to attend the **YES! RETREAT** located at
(Print Name of Adult) *(Event Name)*

Cathedral Camp in **E. Freetown, MA** on **Fri., Mar. 17, 2017, Through Mar. 19, 2017**, and agree to
(Location of Event) *(City/Town and State)* *(Date)*

assume all responsibility associated with this event. I grant to the Parish of _____,
(Name of Parish AND City/Town)
and the Diocese of Fall River, its agents, employees, and representatives my permission to seek emergency medical attention for myself if, in their judgment, such attention is warranted and I am not immediately available to grant such permission. I agree to be in all ways responsible for any and all expenses associated with any and all medical care furnished to me.

The Diocese of Fall River has sufficiently explained the nature, extent, and requirements of this event and I am aware of and accept the associated risks of participation in this event. I agree to release and hold the Parish and the Diocese of Fall River and their agents, employees, and representatives, forever harmless and indemnified against and from any and all claims or right of action for damages which I may acquire either before or after I have reached majority, including but not limited to all bodily injuries and property damages, and including any legal fees in defending such a claim, resulting from, arising out of, or during, or in any way connected with this event. I also agree to release and hold the Parish and the Diocese of Fall River and their agents, employees, and representatives, forever harmless and indemnified against and from any and all claims or right of action for damages which I have or hereafter may acquire either before or after I have reached the majority, including but not limited to all bodily injuries and property damages, and including any legal fees in defending such claim, resulting from, arising out of, or during, or in any way connected with this event.

_____ _____
(Signature of Adult) *(Date)*

Emergency Contact Name & Telephone Number(s) where Contact Person can be reached during the event:

Name: _____ Relationship: _____

(1) (_____)_____; (2) (_____)_____; (3) (_____)_____

Are you currently taking any ***prescription/ over the counter*** medication?_____**NO**___**YES** If yes, please list the medication(s) and their dosages below. Please use the back of this form for additional information.

Medication_____ Dosage_____

Medication_____ Dosage_____

Do you have any allergies to food and/or medications?_____**NO** ___**YES** If yes, please list & explain (use back of form if more space needed)

_____

_____

Participant's Primary Care Physician: _____Physician Phone: _____

Participant's Medical Insurance Company:_____Policy #_____

PHOTO RELEASE INFORMATION:

I grant to the Diocese of Fall River, its representatives and employees the right to take photographs of me and my property in connection with the above-identified subject. I authorize The Diocese of Fall River, its assigns and transferees to copyright, use and publish the same in print and/or electronically.

I agree that the Diocese of Fall River may use such photographs of me with or without my name for any lawful purpose, including but not limited to such purposes as publicity, illustration, advertising, and Web content.

I have read, understand and agree to the above photo release statement._____**NO**___**YES**

_____	_____
(Printed Name of Adult)	*(Signature of Adult)*