ADULT RELEASE OF LIABILITY AND MEDICAL INFORMATION

Diocese of Saint Augustine

I, _____, for and in consideration of being permitted to
(print your name)

participate in the _____ program on
(print name of activity, event, etc.)

_____,20_____ on my behalf and that of my personal representatives, assigns,
(print date or date range of event)

heirs, and next of kin, do hereby release and hold harmless, the Diocese of Saint Augustine, Felipe J. Estévez, as Bishop of the Diocese of Saint Augustine, a corporation sole, Bishop Felipe J. Estévez, individually, all organizers of this program and this event, all volunteers, chaperones, employees and agents of said parties and, their personal representatives or assigns, for any loss or damage on account of any injury to the person or personal property of myself, or death, caused by negligence of the released parties or otherwise, while I am engaged in the above stated program, any of its activities, or transportation to and from the above noted program or activities of the program. I expressly agree that this release, waiver and indemnity agreement is intended to be as broad and inclusive as permitted by the laws of State of Florida, and that if any provision of this agreement is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect. In the event of any emergency, which requires medical or other attention, I hereby give permission to the release parties for myself to be transported to a hospital or like facility for emergency medical, dental, anesthetic or surgical treatment. I further agree to pay for any and all expenses incurred with respect to the emergency and such treatment.

_____ _____

WITNESS DATE SIGNATURE DATE

MEDICAL INFORMATION

Name:_____ Birth date:_____

Address:_____ City: _____

FL Zip:_____ Home Phone (____)_____-_____ Cell Phone (____)_____-_____

In case of emergency, notify:

Name: _____Phone: (____)_____-_____ Relationship: _____

Name: _____Phone: (____)_____-_____ Relationship: _____

Name of Family Doctor: _____ Telephone No.: (____)_____-_____

Do you have insurance: Yes or No Company: _____
(Attach copy of insurance card)

Insurance Policy No.: _____

List Current Medications/Dosages_____

_____

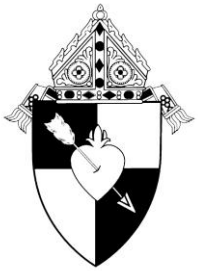
List Current Medical Conditions/Symptoms _____

_____

List allergies/reactions/emergency treatment _____

_____

Date of Last Tetanus Shot_____



Diocese of Saint Augustine
Catholic Center
11625 Old St. Augustine Road
Jacksonville, Florida 32258
(904) 262-3200

Adult Photography Release Form

Without compensation, I hereby grant permission to the Catholic Diocese of Saint Augustine to use and reproduce photographs taken of me. These photographs may be used for news and editorial purposes in publications, electronic reproductions (websites and video) and/or brochures. In addition, I grant my permission to alter the same photos without restriction and to copyright the same. I hereby release the photographer, the journalists and the publications or media outlets they represent, as well as, the parish/church and/or school involved, the Bishop of the Diocese of St. Augustine, a corporation sole, the Catholic Diocese of Saint Augustine and all of their employees and agents, from all claims and liability relating to said photographs.

Name (Printed): _____

Signature: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Cell: _____

Email: _____

Date: _____