CDA - STEUBENVILLE YOUTH CONFERENCE 2010 **T-SHIRT SIZE:_____**

Individual Adult MEDICAL RELEASE FORM **Due Date: _____**

I, _____, as a participant in Steubenville Youth Conference Friday, July 9, 2010 thru Sunday, July 11, 2010, hereby understand and acknowledge that participation in the activities involves inherent risks of injury to myself including risks associated with transportation by motor vehicle. I voluntarily and without reservation and on behalf of myself, my heirs, and my estate, hereby indemnify, defend and hold harmless the Diocesan employees, volunteers, participating parishes, Most Reverend Paul S. Loverde, Bishop, his successors, and the Diocese of Arlington from any and all liability, loss damages, costs, or expenses which are sustained, incurred, or required arising out of my actions in the course of the Steubenville Youth Conference, including the cost of any medical care given to me or any expenses or fees incurred in any lawsuit arising as a result of any damage or injuries caused by me in the course of my participation in the activity.

Informed Consent to Medical Treatment:
In the event of an injury, I hereby give the Diocese of Arlington and/or its parish(es) full authority to take whatever action they feel is warranted under the circumstances regarding my health and safety, if I am not in a condition to give informed consent including but not limited to the application of emergency medical procedures, the admittance to a hospital, or the care of a medical professional at my expense. I have not been given a guarantee as to the results of examination or treatment.

Reimbursement of Medical Expenses:
I recognize and acknowledge there is no volunteer accident coverage nor is there any medical payments coverage available to me in order to compensate me for expenses I incur from deductibles, co-payments, prescription drugs, or medical services not covered through my own health insurance provider(s) for any injury I sustain as a result of performing my services. I agree that any medical coverage(s) I have will be primary and under no circumstance will I seek any contribution from the Diocese, or their insurer, for any medical expenses.

Also, I authorize the Diocese of Arlington to use my picture or video recording for educational and/or marketing purposes. Adults who do not wish to be photographed or filmed should notify the Office of Youth Ministry in writing.

Full Name of Participant

Date of Birth and Year Date of last Tetanus Booster

Known allergies including any allergies to medicine (Continue on back of form if needed)

Any other medical problems which should be noted (Continue on back of form if needed)

Are you currently taking any prescribed drugs? If so please list:

Phone: Home Work Mobile

Social Security Number

Family Physician Name and Phone

Signed Date

Please tape a Xeroxed copy of *both sides* of your insurance card HERE.