Quo Vadis CycloCross/Retreat for High School Boys

Saturday September 25, 2021

Participant's name:_____ Phone: _____

Address: _____City/State/Zip_____

Email address:_____ Date of Birth: _____

Emergency Contact Name: _____

Emergency Contact Phone(s): _____ Relation: _____

Parental permission and liability release:

As parent/legal guardian of the participant named above, I (we) do hereby give my (our) permission to participate fully in the **Quo Vadis Bike Retreat** on **September 25, 2021**. I/we do for myself/ourselves and for and on behalf of my/our child referred to here as 'participant' do forever discharge, agree to hold harmless, and indemnify the Diocese of Arlington, the Most Reverend Michael Burbidge and his successors in office, their clergy, its directors, employees, agents and volunteers from any and all liability, claims, demands for personal injury, sickness and death, as well as property damage and expenses of any nature whatsoever which may be incurred by the undersigned of the participant resulting from said participant's involvement in the above mentioned event (including transportation to and from the event). Furthermore, I/we on behalf of the participant hereby assume all risk of personal injury, sickness, death, damage, and expenses resulting from said participant's involvement in the above described event.

Further, authorization and permission are hereby given to the Diocesan Office of Vocations, its directors, employees and agents thereof to furnish any necessary transportation or food while the named participant is involved in the above described event.

I further give my consent that in my absence the above-named minor be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named minor. I assume full responsibility for all costs of such treatment. Further, should it be necessary for the participant to return home due to medical, disciplinary, or other reasons, I/we do hereby assume responsibility for the participant's transportation home and any costs related thereto.

Health Information: Are there any conditions or allergies which may affect the participant's involvement in the above event?
YES _____ NO _____ If YES, why?

_____

_____

_____

Is there any physician prescribed or other medication which the participant may be taking during the above event? YES _____ NO _____
If YES, please provide name, dosage, and potential side effects of said medications:

_____

_____

Name and phone number of physician or Health/Medical Insurance:
Primary Healthcare Provider: _____ Coverage: _____

I/we understand and hereby agree to the terms and conditions of the participant's involvement in the above described event.

_____ _____

Signature of Parent/guardian Daytime Phone

COVID-19 Protocols: Please be aware that you will not be permitted to participate in this event if:

- You have any symptoms of COVID (cough, shortness of breath, fever over 100.3; chills; muscle aches; sore throat);
- You have been exposed to someone within 14 days of the event who has tested positive for COVID.

Please be respectful of others and do not come if you may have COVID.

Please return this form to the following address by September 20, 2021:
vocations@arlingtondiocese.org OR
Catholic Diocese of Arlington / Office of Vocations / 200 N. Glebe Road, Suite 901 / Arlington, VA 22203