Quo Vadis Seminary Visit

Saturday October 5, 2019

Participant's name:_____ Phone: _____
Address: _____City/State/Zip_____
Email address:_____
Will your father attend? YES _____ NO _____ Father's name: _____

Participant's Commitment
I hereby make a personal commitment to participate fully in the Quo Vadis Seminary Visit and to abide by expected standards of conduct.
Signature of participant: _____

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 Seminary Visit on Saturday, October 5, 2019. 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 F. 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.

Emergency Contact: Name: _____
Phone Number: _____

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

Please mail this form, along with a check for $15 per person made payable to "Catholic Diocese of Arlington," to the following address. Signed forms and payment must be received by September 27, 2019.

Catholic Diocese of Arlington / Office of Vocations / P.O. Box 1960 / Merrifield, VA 22116-1960