DIOCESE OF LITTLE ROCK ~ OFFICE OF CATHOLIC SCHOOLS

VOLUNTEER MEDICAL RELEASE FORM

School Name_____
Name _____
Address_____
City _____State _____ ZIP Code _____
Home Phone #_____ Work Phone #_____
Cell Phone # _____

Physician's Name _____Phone # _____
Date of Birth_____ Date of Last Tetanus Shot _____

Emergency Contact Name _____Phone # _____

Please list **all** medical conditions/allergies/special health information_____
_____
_____

Please list **any** medications (prescriptions or non-prescription) that you would like us to be aware of_____
_____
Medical Insurance Company _____ Policy Number_____
Policy in the Name of _____Relationship _____

In the event that the participant does not have insurance, payment in full for medical care becomes the responsibility of the patient.

I, _____, do hereby release, hold harmless and discharge the Diocese of Little Rock, the school, the parish, its staff and volunteers from any and all liability, claim, loss, damage, cost or expense arising from my participate on in this event. I waive such claims against such organization or any such person, arising directly or indirectly from or attributable in any legal way, to any action or omission to act of any such organization or person in connection with execution of this event. I authorize treatment by a licensed medical physician or licensed medical team in case of any accident or illness that may so arise, or any hospitalization necessary.

Signature _____ Date_____