Form #6

DIOCESE OF LITTLE ROCK ~ OFFICE OF CATHOLIC SCHOOL
FIELD TRIP VOLUNTEER MEDICAL RELEASE FORM

School Name: _____

Parent Name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____

Date of Birth: _____

Physician's Name: _____ Phone #: _____

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 participation 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:

OPTIONAL:

Please list medical conditions/allergies/special health information: _____

_____

_____

_____

Please list 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: _____