Permission and Liability Waiver

Description of Activity/Event:
Date(s): **March 11, 2014 – December 31, 2014**
Type of Event: **Softball**
Arrival/Departure Time: **Mondays, Tuesday, Thursdays**
ER Phone Number:
Destination: **Adams Mill Program Center (GHS Family YMCA)**
Individual In Charge: **Frank Allgood, Athletic Director**
Mode of Transportation: **Personal Transportation**

Participant Information:
Participant's Name: _____
Birth Date: _____ Age: _____ Gender: _____
Spouse's Name _____
Full Address: _____
_____
Home Phone: ( )_____ Cell Phone: ( )_____
Business Phone: ( )_____

Hold Harmless Agreement:
I remain legally responsible for any personal actions taken.

I agree on behalf of myself, my family, our heirs, successors, and assigns to hold harmless and defend
St. Mary Magdalene Catholic Church ,
Parish Name
its officers, directors, agents, and the Diocese of Charleston from any liability for illness, injury or death arising from or in connection with my son's/daughter's attending the above named activity/event.
*Signature of Participant:*_____ *Date:*_____

Permission To Be Photographed:
I give my permission, _____, to be photographed at this event and understand that the photographs may be used for publicity, etc. ___ Yes ___ No
*Signature of Participant:*_____ *Date:*_____

Side A

MEDICAL CONSENT AND PERMISSION TO TREAT

Release of Information:
To the best of my knowledge, I, _____ am in good health, and I assume all responsibility for my health. In the event of an emergency, I give permission to transport me to a hospital for emergency treatment. I wish to be advised prior to any further treatment by the hospital or doctor.

I hereby grant medical personnel permission to release medical information to the Diocesan Director and/or my parish minister in the event that I become ill or injured.
*Signature of Participant:*_____ *Date:*_____

Insurance Information:
Insurance Carrier:_____ Policy Number:_____

Emergency Contact Information:
Name: _____
Full Address: _____
Home Phone: ( ) _____ Cell Phone: ( ) _____
Business Phone ( )_____

If you are unable to reach me, please contact:
Name:_____
Relationship to me:_____

Medical History:
I am under the care of a medical provider. _____Yes _____No
Provider Name: _____Phone Number: ( )_____

I take medication and will bring all medication with me and it will be clearly labeled. I am taking the following medication(s) and directions for taking this medication, including dosage, frequency and storage are as follows: _____
_____
_____
_____
_____

*Signature of Participant:*_____*Date:*_____

Side B