NOTRE DAME HIGH SCHOOL

Member of the Middle States Association of Colleges and Secondary Schools
3417 Church Road, Easton, PA 18045
610 868-1431 Fax 610 868-6710 www.ndcrusaders.org

DIOCESE OF ALLENTOWN
ADULT PARTICIPATION FORM& RELEASE

Participant's name_____
Birth date: _____ Sex: _____
Home address: _____
Home phone: _____ Business phone: _____

I, _____, agree and understand that I assume the risks inherent in the field trip or other activity outside of my child's school, and with full knowledge of the risks, I, and my heirs, successors and assigns, release and agree to hold harmless and defend **Notre Dame High School Inc.,**
The Diocese of Allentown, Most Reverend Alfred A. Schlert, D.D., J.C.L. the Roman Catholic Diocese of Allentown Charitable Trust, and all of their respective members, trustees, directors, officers, employees and representatives, including chaperones, volunteers or any other representatives associated with that activity (all of whom are separately and collectively referred to as the Diocese) from claims from or related to my participation, or in connection with any illness or injury (including death) or cost of medical treatment in connection therewith, and I agree to compensate the Diocese for reasonable attorney's fees and expenses incurred by the Diocese in any action brought against the Diocese as a result of such injury or damage, unless such claim results from the negligence of the Diocese.

Description of trip:
Type of event: _____
Destination of event: _____
Estimated time of departure and return: _____
Travel information (airline, flight numbers, bus or train information):_____

Medical Matters: I hereby warrant that to the best of my knowledge, I am in good health, and I assume responsibility for my health.

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to be transported to a hospital for emergency medical or surgical treatment. In the event of an emergency, contact:
Name & Relationship:_____Phone:_____
Family doctor:_____Phone:_____

Medical Insurance Information:
Health Plan Carrier: _____
Policy #: _____
I.D. #: _____
Specific Medical Information: The parish/school should be aware of the following medical conditions. (The parish/school will take reasonable care to see that the following information will be held in confidence.)
Allergic reactions (medications, foods, plants, insect, etc.):_____
Physical limitations or other special medical conditions: _____

I have read carefully this entire (page 1) Adult Participation Form and Release and agree to its terms and intend to be bound hereby.

Participant's signature: _____ Date: _____