Diocese of Paterson

HEALTH INFORMATION/RELEASE OF LIABILITY/CONSENT TO TREAT

I/we request that my/our son/daughter attend the __________________________ (name of event) under the auspices of Our Lady of the Mountain Church to be held at ___________________on _______________________ (date). I/we have read the foregoing Health Information /Release of Liability / Consent to Treat Form and the answers are all correct.

I/we can be reached at the telephone numbers referred to above but if emergency medical care of treatment shall be necessary and if I/we cannot be contacted, I/we authorize the delegated agents of Our Lady of the Mountain Church to act on my/our behalf and approve appropriate treatment.

Release of Liability: In consideration of Our Lady of the Mountain Church accepting my/our son's/daughter's registration for this event, I/we release, hold harmless and discharge Our Lady of the Mountain Church, its officers, Trustees, employees, agents and affiliates, as well as the Roman Catholic Diocese of Paterson and Bishop Arthur J. Seratelli, S.T.D., S.S.L., D.D. and or his successor, as well as any and all agents and /or employees of the Roman Catholic Diocese o f Paterson from any and against all liability, claim, loss, damage. Cost or expense including counsel fees remitting from any and all claims for bodily injury and /or property damage and I we further waive any such claims against any such person or any such person or organization in connection with this event and I/we further agree to indemnify and hold harmless the parish and its aforesaid affiliated personnel from any such liability, claim, loss, damage, cost or expense as already set forth.

Date________________
Witness___________________________parent or guardian- indicate which and
if guardian, give details on back
Witness
Address____

Approve and sign off where applicable
Pastor if parish related _________________
Principal if school related_______________
Agency Director if agency_______________

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First Name____________________________Last Name_________________________

Address ______________________________City/State/Zip_______________________

Name of
Parent(s)/Guardian(s) ____

Home Phone#____________________________Work Phone#____________________

Health Insurance Company__________________________Policy#________________

Male/Female______Age______Birth Date_______Grade____Youth____Adult_____

Parish __________________________ Parish City______________________________

Are you currently under the care of a doctor, psychologist or psychiatrist? __________

Name of Family Physician _____________________Phone#______________________

Last Tetanus shot_________

Allergies to Drugs/Foods_____ Explain on back

Do you have any special dietary needs or restrictions?____________________________

Special Medications, blood type or pertinent medical________ Explain on back

Witness__________________________ Applicant's Signature____________________

Witness Address____