

**ADULT FORM B**

**DIOCESE OF COVINGTON  
CONSENT FORM AND LIABILITY WAIVER**

Participant's Name \_\_\_\_\_

Birth Date \_\_\_\_\_ Sex \_\_\_\_\_

Home Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

I agree on behalf of myself, my heirs, successors, and assigns, to hold harmless and defend (name of parish) \_\_\_\_\_, its officers, directors and agents, and the Diocese of Covington, chaperons, or representatives associated with the activity as described herein for any claim or damages to any property, arising from or in connection with my attendance at the activity or in connection with any illness or injury or cost of medical treatment in connection therewith, and I agree to compensate the parish, its officers, directors and agents and the Diocese of Covington, chaperons, or representative associated with the activity for reasonable attorney's fees and expenses arising in connection therewith.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**ACTIVITY INFORMATION**

Activity \_\_\_\_\_ Date \_\_\_\_\_ Cost \$ \_\_\_\_\_

Location \_\_\_\_\_ Phone (emergency) \_\_\_\_\_

Starting Time \_\_\_\_\_ Meeting Place \_\_\_\_\_

Ending Time \_\_\_\_\_ Meeting Place \_\_\_\_\_

Type of Transportation \_\_\_\_\_ Contact Person \_\_\_\_\_ Phone \_\_\_\_\_

Other Information \_\_\_\_\_

**MEDICAL INFORMATION**

**PLEASE PRINT**

Allergies \_\_\_\_\_

Medications \_\_\_\_\_

Chronic Conditions (e.g. epilepsy, diabetes) \_\_\_\_\_

Medical Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Member's Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_