ADULT FORM

DIOCESE OF VICTORIA IN TEXAS
PERMISSION FORM/MEDICAL RELEASE FORM

NAME ____ **Sex:** __________ **Age** ____________

Address _________________________________ **City/State/Zip** ______________________________

Home Phone (_____)______________________ **Mobile Phone** (_____)________________________

Birthdate _________________________________ **Parish/City** _________________________________

I would like to participate in youth activities/faith formation programs sponsored by Holy Cross Catholic Church of Diocese of Victoria in Texas from June 1, 2018 to July 31, 2019. I agree to defend, indemnify and hold harmless the Diocese of Victoria, its' clergy, officers, agents, employees, and volunteers from any claims, costs or expenses for property damages, personal injuries or other damages arising out of my participation in the above mentioned activity. In case of an emergency, I grant permission and authorization for a designated adult representative or the Office of Youth & Family Ministry to sign for treatment by a local physician and/or hospital selected by an adult representative of Holy Cross Church of the Diocese of Victoria in Texas.

Date ____________________________ **Signature** ____

Family Physician _________________________________ **Phone** (_____)________________________

Address _________________________________ **City/State/Zip** ______________________________

1. Are you allergic to any type of medication? If so, please indicate: _____________________________

Describe reaction? ____

2. Are you presently taking any prescription medicine over an extended period of time? ______________

Name of medication: ____________________________ What is it for? ___________________________

3. Do you have any allergies? ________________ If so, what are they? ___________________________

Last immunization/booster for Diphtheria/Tetanus: ____

Name of Insurance Company ______________________________ **Phone** (_____)________________

Address _________________________________ **City/State/Zip** ______________________________

Name of Insured ___________________________ **Policy or Group Plan #** ______________________

Emergency Contact Numbers:

Name _________________________ **Home Phone** (_____)_____________ **Mobile**(____)________________

Name _________________________ **Home Phone** (_____)_____________ **Mobile**(____)________________