

**Diocese of Rockford – Respect Life Office
Adult/Chaperone Participation Agreement -Page 2**

Medical History

**** PLEASE HAVE YOUR INSURANCE CARD WITH YOU AT ALL TIMES**

Physician's Name: _____ Phone: (____) _____

Special Needs: _____

In the event of an emergency contact the following:

Name: _____ Relationship: _____

Home Phone: (____) _____ Work #: (____) _____ Cell #: (____) _____

Character references

Please provide two non-relative character references:

Name: _____ Title: _____ Phone: (____) _____

Name: _____ Title: _____ Phone: (____) _____

Agreements

- 1. In signing this form, I hereby state that the information included in this form is correct.**
- 2. In the event that I am not coherent or conscious, I hereby grant the staff, volunteers or agents of the Diocese of Rockford permission to act on my behalf in seeking emergency medical treatment for myself in the event that such medical treatment is deemed necessary.**
- 3. I agree to accept any and all financial responsibility as a result of emergency medical treatment.**
- 4. I recognize that there are risks inherent in participation in any activity and agree to hold the Diocese of Rockford, its affiliates and its and their employees, volunteers and agents, harmless from any injury to myself or damage to or loss of my personal property not caused by the negligence or misconduct of the Diocese of Rockford, its affiliates and its and their employees, volunteers and agents.**
- 5. I understand that for all Respect Life Office activities there is a zero tolerance policy for the use of any mood altering chemicals, including alcohol and illegal drugs, foul language, threats or any type of abuse and inappropriate physical contact.**
- 6. I understand that photography of the Pilgrimage, events, sites and participants may be used by the Diocese of Rockford without further permission.**

I agree to follow this policy.

Signature: _____ **Date:** _____