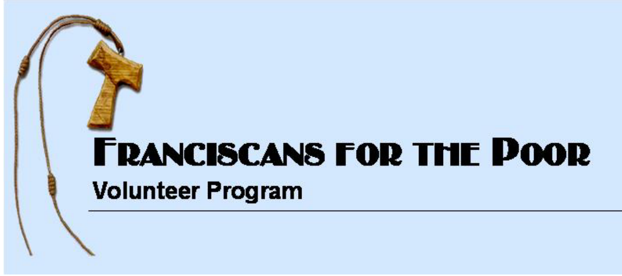
ADULT

Waiver and Emergency form



Permission, Release & Medical Power of Attorney and Photo Release form

Group Name: ____

Dates of Mission Trip: ____

1) I, ________________________________, the participant give permission to volunteer for the Franciscans for the Poor. I release from all liability and indemnify the Franciscans for the Poor, the Franciscan Sisters of the Poor and the Archbishop of Cincinnati ("the Archbishop"), both individually and as trustee for the Archdiocese of Cincinnati and all parishes within the Archdiocese, and their officers, agents, representatives, volunteers and employees from any and all liability, claims, judgments, cost or expenses, including attorney fees, arising out of any injury or illness incurred by me while participating in or traveling to or from the activity.

2) I agree to cooperate with the Archbishop or his agents in charge of the activity.

3) Emergency medical consent:
   a) I appoint the Archbishop and his agents who are acting as leaders of the activity as my attorney in fact to act for me in my name and my behalf, in any that I would act if I were personally present, with respect to the following matters if any injury, illness or medical emergency occurs during the activity or related travel:
      i) To give any and all consents and authorizations to any physicians, dentist, hospital or other persons or institutions pertaining to any emergency medications, medical or dental treatments, diagnostic or surgical procedures or any other emergency actions as our attorney shall deem necessary or appropriate for the best interest of my health.
      ii) I understand that the agents of the Archbishop will make a reasonable attempt to contact my next of kin as soon as possible in the event of a medical emergency involving me.
   b) This power of attorney shall lapse automatically upon completion of the activity and related travel.

4) I agree that the Archbishop or his agents may use my portrait or photograph for promotional purposes, website and office functions.

______________________________ ______________________________

Participant's Name Participant's Signature

Please see page 2 for emergency contact information

ADULT

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Name

Street **City** **State** **ZIP**

( )
Home Phone

( )
Next of Kin's Emergency Phone Number

( )
Participant's Cell phone

( )
Other emergency contact's phone number

( )
Alternate emergency numbers

Relationship to Participant

Physician's Name

( )
Physician's Phone Number

Chronic or Recurring Illnesses:

Medication(s) & Dosage(s):

Allergies to food, drugs or environment:

Other information beneficial in case of emergency:

Health Insurance

Insurance Company ______________________ **Policy or Card #** ______________

Group # ______________________ **Claims Phone #** ______________

The following over-the-counter medicines are available at Tau Community House. Please √ any medicine that this participant **cannot** take.

____ Tylenol/Acetaminophen
____ Advil/Ibuprofen
____ Allergy/sinus medication
_____ Pepto-Bismol/Antacid
_____ Airborne (Vitamin C)
_____ Other (List below)

If the participant does not have a copy of his/her insurance card in their wallet, then please make a copy of the participant's insurance card and attach to this form. This ensures quicker processing in case of a medical emergency.