

**LIABILITY/MEDICAL RELEASE FORM – ADULT PARTICIPANT**  
**ONE FORM MUST BE COMPLETED FOR EACH ADULT ATTENDING!**

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

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Group Name \_\_\_\_\_

Group Leader's Name \_\_\_\_\_

I, \_\_\_\_\_ (name), am attending **March for Life Teen Pilgrimage** to be held on **January 21<sup>st</sup> and 22nd in Washington D.C.** If needed for health reasons, I give permission for myself to be evaluated, diagnosed, treated and/or given medication in accordance with standard medical practice by licensed medical personnel. I relieve the Diocese of Bridgeport of all responsibility and consequences that may arise as a result of this treatment. I will not hold the Diocese of Bridgeport liable in the event of injury. Further, I agree to accept any and all financial responsibility as a result of scheduling medical treatment.

I agree to abide by all rules and regulations stated by the Diocese of Bridgeport. I understand that any Diocese of Bridgeport staff will not be held liable if I fail to cooperate with regulations, and that any infraction of the rules may result in immediate dismissal from the event at my expense.

I give permission to any the Diocese of Bridgeport staff to photograph, videotape and/or film myself and to use my image in photographs, video, and/or film for the purpose of promoting the mission, activities, and programs of the **March for Life Teen Pilgrimage**. I understand that I am not entitled to any compensation or rights in these materials, and I release the Diocese of Bridgeport from any liability for the use of my image for the above stated purposes.

**DATE:** \_\_\_\_\_

**SIGNATURE OF ADULT PARTICIPANT**

Family Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Allergies or Medical Conditions (be specific) \_\_\_\_\_

Current Medications \_\_\_\_\_

Medical History (be specific) \_\_\_\_\_

Medical Insurance Provider \_\_\_\_\_ Insurance # \_\_\_\_\_

*In case of emergency, please contact:*

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

**Please return this form and a check for \$100 to Mimi Giannino at the Catholic Center at 238 Jewett Ave, Bridgeport, CT 06606 no later than January 8<sup>th</sup>.**