

Diocese of El Paso and/or Parish of \_\_\_\_\_  
Adult Liability Waiver, Medical Release and Promotional Release Form

\*\*All adults participating in parish and/or diocesan religious formation events/trips must fill out this form\*\*

Adult Participant's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell: \_\_\_\_\_ Do you text?  Yes  No

Have you completed the Diocese of El Paso Safe Environment Program (Virtus Training)?  Yes  No

If so, provide the date of completion or renewal: \_\_\_\_\_ Where did you attend training?: \_\_\_\_\_

I agree on behalf of myself, my heirs, successors, and assign to hold harmless and release the Diocese of El Paso, Bishop of the Roman Catholic Diocese and his successors in office, diocesan employees, volunteers and the parish of \_\_\_\_\_ religious formation program, their officers, directors, and agents from any liability (unless due in part to gross negligence of the diocese and/or parish) for illness, injury or death arising from or in connection with my attending a religious formation ministry event or trip beginning the 1<sup>st</sup> day of June, 2018 through the 31<sup>st</sup> day of May, 2019.

In the event any legal action is taken by either party against the other party to enforce any of the terms and conditions of this agreement, it is agreed that the unsuccessful party to such action shall pay to the prevailing party therein all court costs, reasonable attorneys fees and expenses incurred by the prevailing party.

In the event that I should require medical treatment and I am not able to communicate my desires to attending physicians or other medical personnel, I give permission for the necessary emergency treatment to be administered.

Please advise the doctors that I have the following allergies: \_\_\_\_\_.

In case of an emergency and for permission for treatment beyond emergency procedures, please contact:	
Emergency Contact Name: _____	
Relationship to me: _____	
Cell Phone: ( _____ ) _____	Home Phone: ( _____ ) _____ Texting: Yes <input type="checkbox"/> No <input type="checkbox"/>

Health Insurance Carrier: \_\_\_\_\_

Insurance ID Number: \_\_\_\_\_ Insurance Policy Number: \_\_\_\_\_

**Please attach a copy, front and back of your Medical Insurance Card**

**Promotional Release**

I also consent to the use of any videotapes, photographs, or any other visual reproduction (in perpetuity unless otherwise revoked by me in writing and delivered by certified mail, return receipt requested, to: Centro San Juan Diego, 901 W. Main Dr., El Paso, TX 79902 (ATTN: Director, Office of Religious Formation)) in which I may appear by the Diocese of El Paso. I understand that these materials, including websites and social media sites, are being used for promotion of the Religious Formation ministry of the Diocese of El Paso, which may include recruitment and fundraising efforts.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date