RELEASE OF CLAIM and EMERGENCY AUTHORIZATION FORM
SHEIL CATHOLIC CENTER – NEW ORLEANS TRIP
March 24th –April 2nd, 2018

Please read this form carefully.

Agreement Regarding Liability:
I agree to assume any and all risk of bodily injury, death, or property damage arising out of, or caused by my presence and participation in this service trip.

I agree to waive and relinquish all claims that I may have against Sheil Catholic Center, the Archdiocese of Chicago, Northwestern University, their officers, agents, servants, employees, drivers, and volunteers relating to Sheil Catholic Center.

I hereby fully release and discharge Sheil Catholic Center, the Archdiocese of Chicago, Northwestern University, their officers, agents, servants, employees, drivers, and volunteers relating to Sheil Catholic Center from any and all claims from injuries, including death, damage or loss, that I, my heirs and/or legal representatives may have or which may accrue to me on account of my activities.

I further agree to indemnify and hold harmless and defend Sheil Catholic Center, the Archdiocese of Chicago, Northwestern University, their officers, agents, servants, employees, drivers, and volunteers relating to Sheil Catholic Center from any and all claims resulting from injuries including death, damages and losses sustain by me, or sustained by others and caused by me, and arising out of, connected with, or in any way associated with my activities on their property. This Agreement also pertains to the individuals who help me.

Emergency Treatment Authorization & Insurance Information
I hereby authorize permission for the administration of first aid to myself by the people in charge of the program and those transporting me to and from the program as their judgment deems advisable, and to make the necessary referrals to qualified physicians for treatment of illness or accidents of a more serious nature.

I hereby authorize the treatment by a qualified and licensed doctor in the event of a medical emergency which, in the opinion of the attending physician, may endanger my life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach the Emergency Contact listed on the opposite side of this form. I agree to provide medical insurance and pay all costs and expenses incurred in connection with such medical and dental services rendered to me.

Signature
I have carefully read and fully understand this *Release of Claim and Emergency Authorization Form* and I sign it of my own free will.

Participant's Name (please print): _____

Participant's Signature: _____ Date: _____

MEDICAL INFORMATION

Participant's Name (please print): _____

Address (Dorm): _____

Phone Number: _____

Emergency Contact
Name and Phone Number: _____

Emergency Contact (Alternate): _____

Name of Physician: _____

Physician Phone Number: _____

Health Insurance Company: _____

Health Insurance Policy Number: _____

Health Insurance Phone Number: _____

Specific Medical Allergies: _____

Dietary Restrictions: _____

Chronic Illness or Conditions: _____

Other: _____

Participant's Signature: _____ Date: _____