ADULT CHAPERONE REGISTRATION FORM

March for Life 2018

(Must be completed by all adult participants)

Please check all that apply: _____ Group Leader _____ Chaperone

Name: ____

Address: ____

City: ___________________ State: _____ Zip code: ___________

Phone: Home __________________ Cell __________________

E-mail: ____

Parish: __________________ Gender: _____ DOB: ________

To register for this pilgrimage, all adult participants must complete the Archdiocesan Field Trip Adult Liability Waiver.

Contact your group leader for cost and expectations of chaperones on the March for Life.

By registering for this pilgrimage, I agree to follow the rules and code of conduct established by the Archdiocese of Mobile, Office of Youth Ministry, and my parish. I recognize that I could be removed from the pilgrimage for not complying with the rules, and that my removal would be reported to proper parish and/or school administration. I will not bring illegal drugs, alcohol, or weapons to the March for Life.

Signature: ____

Date: ___________________

FIELD TRIP
ADULT LIABILITY WAIVER

(Adult leaders and chaperones)

MARCH FOR LIFE PILGRIMAGE 2018

I, ______________________________ agree on behalf of myself, my heirs, assigns, executors, and personal representatives, to hold harmless and defend ________________________________ School/Parish/Institution, and the Archdiocese of Mobile, its officers, directors, employees, or representatives associated with the field trip from any and all liability claims, loss or damage arising from or in connection with my participation in the field trip.

Signature: _________________________________ Date**:** __________________________

Medical Matters: I hereby warrant that to the best of my knowledge, I am in good health.

Emergency Medical Treatment*:* In the event of an emergency, I hereby give permission to transport me to a hospital for emergency medical or surgical treatment.

Specific Medical Information that may impact medical treatment: ____________________________
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In the case of an emergency contact:
Emergency contact person: ____

Emergency Contact's Cell Phone: ____________________ Other Phone: ____________________

Family doctor: _________________________________ Phone: ________________________

Family Health Plan Carrier: _________________________ Policy #: _____________________

Date of Birth: _____________________________________

Signature: ___________________________________ Date: __________________________

Printed Name: ____