

## ADULT CHAPERONE REGISTRATION FORM

**March for Life 2020**

(Must be completed by all adult participants)

Please check all that apply: \_\_\_\_\_ Group Leader    \_\_\_\_\_ Chaperone

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Phone: Cell \_\_\_\_\_ Alternate \_\_\_\_\_

E-mail: \_\_\_\_\_

Dietary Restrictions (if applicable): \_\_\_\_\_

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 & Young Adult 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 2020

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

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: \_\_\_\_\_