EMERGENCY MEDICAL/PERMISSION FORM-Diocese of Grand Island, NCYC 2017 Pilgrimage
***This form required by all adult participants**

This release is effective from **November 15, 2017** to **November 19, 2017.**

I, _____ (name), hereby grant the **Diocese of Grand Island** and their staff of the **National Catholic Youth Conference** permission to transport me to an emergency medical or health care facility for immediate treatment and/or consultation, if deemed necessary. Furthermore, I understand that my designated person will be notified of any emergency situation immediately. I give authorization to the attending physician, dentist, or medical personnel for any required immediate treatment in the event that I cannot make the decision at the time of the emergency. I agree to be financially responsible for any and all medical expenses and/or treatment costs and all related services provided. I release the **Diocese of Grand Island** and the **National Catholic Youth Conference** staff from any liability in the event I am injured during this event.

I understand that this event is sponsored by the **Diocese of Grand Island**. I hereby grant permission for myself to participate in the **National Catholic Youth Conference** including being transported by staff to and from some activity sites during the pilgrimage and accept full responsibility for any legal or financial consequences which may result from any personal actions (i.e. damage to property or other participants/staff) taken by ME, and I agree to hold the **Diocese of Grand Island** and the **National Catholic Youth Conference** staff harmless with respect to any actions or claims that may be made in connection with personal actions taken by ME.

I authorize the release of information to my insurance company and family physician:

Insurance Company Name: _____
Address: _____
Phone: _____ **Policy #** _____
Physician's Name: _____
Address: _____
Phone: _____

I have the following allergies (**including food allergies):**

_____
_____
_____

I have the following medical conditions (**including mental health or pregnancy**):

_____
_____
_____

I am currently taking the following medications:

_____
_____
_____

Signature: _____ **Date**: _____

In case of emergency, please contact:

Name: _____Relationship to participant: _____
Address: _____
City: _____State:_____Zip:_____
Home Phone: _____E-mail_____
Work Phone: _____ (ask for _____)
Work Phone: _____ (ask for _____)