

**Event and Medical Release Form for Adults  
Participating in Diocese of Bethlehem**

Please Note: All information given is confidential and is not distributed to unauthorized personnel.

Event and Date: \_\_\_\_\_

Name of Participant: \_\_\_\_\_ Select: Male: \_\_\_ Female: \_\_\_

Participant's Email: \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_ Age: \_\_\_ Phone: \_\_\_\_\_

Home parish (if applicable) \_\_\_\_\_

**Medical Information and Release:**

1. Any physical or emotional health problems the staff should know about (if more space is needed write on back of page) \_\_\_\_\_

2. Any allergies: \_\_\_\_\_

3. Any dietary restrictions: \_\_\_\_\_

4. I give my permission for images of me to be used in Diocesan Publications, online and in print for future events and promotions. These images may include still photographs or video images. \_\_\_\_\_ yes \_\_\_\_\_ no

**Emergency contact during event:**

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

Relationship: \_\_\_\_\_ 2nd Phone (if applicable): \_\_\_\_\_

In case of a medical emergency, I permit the event staff and/or adult supervisors to obtain or authorize emergency medical/dental treatment for me. I further authorize the medical personnel selected by the diocesan staff and/or adult supervisors to administer such emergency treatment, including injections, anesthesia, or surgery as they deem necessary. I understand I will be notified of this emergency as soon as possible.

Signature: \_\_\_\_\_ Date \_\_\_\_\_