



DIOCESE of
LA CROSSE

Adult Participant Event Release Form

Please fill out this form for anyone who is age 18 (out of high school) and older.

PARTICIPANT'S NAME (First, Middle, Last):	DATE OF BIRTH:
PARISH/SCHOOL:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE

Activity/Event Information

NAME OF ACTIVITY/EVENT:	DATE(S) OF ACTIVITY/EVENT:
DESIGNATED LEADER:	DESIGNATED LEADER'S TITLE/POSITION:
DESTINATION OF ACTIVITY/EVENT:	
MODE OF TRANSPORTATION TO AND FROM ACTIVITY/EVENT:	
DEPARTURE DATE/TIME:	RETURN DATE/TIME:

Hold Harmless/Liability Waiver

The above named Participant agrees to defend, protect, indemnify and hold harmless the above named Parish/School, The Diocese of La Crosse, and its Bishop against and from all claims arising from the negligence or fault of the above named Participant or any of their agents, family members, officers, volunteers, helpers, partners, organizational members or associates which arise out of the above named Activity/Event at the above named Destination.

Additionally, the above named Participant agrees to protect, defend, hold harmless and fully indemnify the above named Parish/School, The Diocese of La Crosse, and its Bishop for any claim or cause of action whatsoever arising out of the above mentioned Activity/Event which takes place during the above identified Dates of Activity/Event that is brought against the Parish/School, The Diocese of La Crosse, and its Bishop by the above named Participant or their family members whether such claim arises from the alleged negligence of the Parish/School, The Diocese of La Crosse, and its Bishop, its employees or agents or Participant's negligence. If any portion of this agreement is held invalid, it is agreed that the balance thereof, shall continue in full legal force and effect.

PARTICIPANT INITIALS:	DATE:
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Statement of Truth and Accuracy:

I acknowledge that I have previously completed the "Adult Medical Release Form," providing medical information, permissions, authorizations and releases. I have listed below any additions and/or corrections to the information provided on that form. Subject to any changes, I hereby reaffirm any and all such disclosures, permissions, authorizations and releases as though stated herein.

Medical Release Form Additions/Corrections (as applicable).

PARTICIPANT INITIALS:	DATE:
PARTICIPANT SIGNATURE:	DATE: