DIOCESE OF BAKER QUO VADIS RETREAT

ADULT HELPER/CHAPERONE APPLICATION FORM

Please mail your Application Form & Liability Waiver by AUGUST 30, 2017 to the Diocese of Baker so that we can verify that you have completed a Background Check, Darkness to Light and Code of Conduct.

Mail to: Diocese of Baker • Attn: Quo Vadis Retreat
641 SW Umatilla Ave • Redmond, OR 97756

Name ____ Men __ (only)
Please Print

Address ____

City________________________State________Zip Code _____________________

Phone______________________________Cell Phone ____________________________

Your Email: ____

Date of Birth ______________

Parish______________________________City ________________________________

____ Date_____________________

Signature

Thank you for volunteering to help at our Quo Vadis Retreat. Without dedicated adult volunteers we would not be able to sponsor this event. The Lord bless you for your merciful heart. ~David Bisono

(Please turn over and fill out the Adult Liability Waiver)

ADULT LIABILITY WAIVER

Each adult participant, including group leaders and chaperone, must sign this form.

RELEASE OF LIABILITY/MEDICAL RELEASE

I,________________________________, agree on behalf of myself, my heirs, assigns, executors, and
Full Name
personal representatives, to hold harmless and defend The Roman Catholic Bishop of the Diocese of Baker, Inc., its officers, directors, agents, employees, or representatives from any and all liability for illness, injury or death arising from or in connection with my participation in the event.

In the event that I should require medical treatment and I am not able to communicate my desires to attending physicians or other medical personnel, I give permission for the necessary emergency treatment to be administered. Please advise the doctors that I have the following drug allergies:

____

____;

and dietary allergies and restrictions: ____.

In case of an emergency and for permission for treatment beyond emergency procedures, please contact:

Name:____Relationship to me: __________________________

Daytime Phone:_____________________________Night time Phone: ______________________________

Cell Phone:_________________________________Health Insurance Carrier: _________________________

Insurance ID Number:_______________________Insurance Policy Number: __________________________

____ ______________________________
Signature Date

____
Print Name