REGISTRATION FORM AND LIABILITY WAIVER

One form per person. Children and teens must be accompanied by a parent.

Parish/School: St. John the Baptist Catholic Church and School, New Brighton, MN

Nature of Activity: Family Pilgrimage to Our Lady of Guadalupe Shrine, La Crosse WI

Date: Saturday, May 5th from 8 am - 8 pm

Transportation: Charter Bus (Families have the option of meeting us at the Shrine at 11:30 am)

Cost: $25.00 per person or $60.00 Family Cap
$10.00 per person box lunch from Café Cucina

______ I will be riding the bus ($25.00 per person or $60.00 family cap)

______ I will be driving my family and meeting the group at 11:30 am at the Shrine

______ I would like the box lunch for $10.00 from Café Cucina

______ I will bring a bag lunch

______ Total Amount Enclosed

First Name ______________________________ Last Name ______________________________

Address ______________________________________ City ______________________________

Phone ____________________________ Email ____

RELEASE OF LIABILITY

The undersigned, his/her personal representatives, heirs and assigns, DO HEREBY:

1. RELEASE, DISCHARGE AND COVENANT NOT TO SUE St. John the Baptist Catholic Church and School and the Archdiocese of Saint Paul and Minneapolis, MN for any and all claims and liability, except for those arising out of the strict liability or negligence of releasee which causes the undersigned injury, death or property damage and further agrees to hold releasee harmless and indemnify releasee from any claim, judgment or expense releasee may incur by participation in the described activity.
2. UNDERSTAND that participation in the described activity involves potential danger and risk of injury. The inherent danger is understood and voluntarily assumed.

I HAVE READ THIS DOCUMENT. I UNDERSTAND IT IS A RELEASE OF ALL CLAIMS. I UNDERSTAND I ASSUME ALL RISK INHERENT IN THIS ACTIVITY. I VOLUNTARILY SIGN MY NAME EVIDENCING MY ACCEPTANCE OF THESE PROVISIONS.

______________________________________ ______________________________________

Printed Name of Participant Date

____

Signature (or of parent if participant is a minor still living at home)

OPTIONAL MEDICAL INFORMATION: I elect not to provide medical information _____ (initial)

My Health Plan carrier number ________________________

Medication(s) I may be taking _________________________ Allergies _________________________________

Other Medical Conditions ____

My Doctor __________________________________ Phone Number __________________

EMERGENCY MEDICAL TREATMENT: In the event of an emergency, I give permission to be transported to a hospital for medical treatment. In the event of any emergency, contact: __________________________________

EMERGENCY CONTACT: Name: _____________________________ Phone: _____________________________

I agree to all of the above stated considerations and conditions.

____________________________________ ______________________________

Signature (or of parent if participant is a minor still living at home) Phone Number