

Eagle Eye Registration

(Adults-including group leaders and chaperones)

Name: _____ **Circle One:** Participant / Chaperone / Volunteer

Check one: College _____ High School _____ N/A _____ **T-Shirt size:** _____

Birth date: _____ **Gender:** Male / Female

Current address: _____
Street, city state zip code

Permanent address: _____
Street, city state zip code

Home phone: _____ **Business phone:** _____

Cell phone: _____ **Email address:** _____

Name/Type of event: _____

Destination of event: _____

Individuals in charge: Congregation of St. John

Estimated time of departure and return: _____

Mode of transportation to and from event: _____

Do you play an instrument? _____

If yes, can you bring it to the retreat? _____

What sports do you like to play? _____

How did you hear about Eagle Eye? _____

Have you been to any Eagle Eye events before? Which ones? When? _____

**FIELD TRIP
LIABILITY WAIVER**

(Adult-including group leaders and chaperones)

RELEASE OF LIABILITY

I, _____ (full name), agree on behalf of myself, my heirs, assigns, executors and personal representatives, to hold harmless and defend _____ Congregation of St. John (School/Parish), Eagle Eye and the Catholic Diocese of Peoria, its officers, agents, employees or representatives associated with the field trip from any and all liability claims, loss or damage arising from or in connection with my participation in the overnight trip.

Signature

Date

Print Name

Authorization for Emergency Medical Treatment

This information will be kept in the possession of the parish and distributed to the person in charge of each and every trip on which I participate. Should the need arise, this information will be given to the proper medical authorities.

I, _____ [name of participant], understand that in the case of my illness, Congregation of St. John [name of parish], will try to notify the person I have listed below as an emergency contact.

In case of medical emergency concerning myself, at a time when my listed emergency contact cannot be notified, I grant full power to the parish supervising employee to do as follows:

1. Arrange for the transportation of myself, whether by ambulance or otherwise, to a proper facility where emergency medical treatment would normally be administered, including but not limited to, an emergency room of a hospital, a doctor's office, or a medical clinic; and
2. Sign releases as may be required in order to obtain any medical or surgical treatment as is required in the judgment of medical authorities at the facility.

Signature

Printed Name

Date: _____

STATE OF ILLINOIS)
) SS.
COUNTY OF _____)

SIGNED AND SEALED before me this ____ day of _____, 20__.

NOTARY PUBLIC

This Authorization for Emergency Medical Treatment is valid for a period of one year, from June __, 20__ through June __, 20__.

10/03/03
Adult

MEDICAL INFORMATION

Name (first, middle, last): _____

Address: _____

Emergency Contacts

Name (first, middle, last): _____

Phone (including area code): _____

Other Contact:

Name (first, middle, last): _____

Relationship (friend, relative,
neighbor, etc.): _____

Phone (including area code): _____

Regular Physician

Name (first, middle, last): _____

Phone (including area code): _____

4/7/03
Adult

Medical Conditions

Please list any medical conditions (asthma, diabetes, epilepsy, etc.):

Please list any allergies or allergic reactions to medications:

Please list any medications you are now taking:

Date of your most recent tetanus shot: _____

Other pertinent medical information:

Medical Insurance Information

Company: _____

Identification number of plan: _____

Identification number of covered employee: _____