Eagle Eye Registration

(Adult-including group leaders and chaperones)

Name: ____ **Circle**: Participant / Chaperone / Volunteer

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

Birth date: ____ **Sex**: ______________________________

Current address: ____
Street, city state zip code

Permanent address: ____
Street, city state zip code

Home phone: ___________________________ **Business phone**: ___________________________________

Cell phone: ____________________________ **Email address**: ____________________________________

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: ____

How did you hear about Eagle Eye? ____

____

____

____

Have you been to Eagle Eye events before? Which ones? How long? ____________________

____

____

____

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), _____________________ 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

2/24/03

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 August _31_, 20__ through August _31_, 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: ________________