San Jose Cursillo Participant Activity Waiver Form

General Liability

Retreat House	
Location Name: St. Clare's Retreat Center	**Location #**: N/A
Location Address: 2381 Laurel Glen Rd, Soquel, CA 95073	Telephone: (831) 423-8093
	Email: stclaresretreatcenter@gmail.com
NOTICE TO ADMINISTRATORS/SUPERVISORS: THIS FORM MUST BE COMPLETED, SIGNED AND FILED ELECTRONICALLY AT THE PARISH. REFER ANY QUESTIONS TO LOSS CONTROL & PREVENTION TELEPHONE: 408-983-0237 OR THERESA.LAVOUN@DSJ.ORG	
Participant Personal Information	
Participant Name:	Telephone:
Home Address:	
Email:	
Medical Plan Name:	Policy Number:
Member ID:	Group Number:
Medical Plan Address:	Telephone:
Emergency Contact Name:	Telephone:
Emergency Contact Name:	Telephone:
Activity Information	
Date of Weekend:	Name of Activity: **Cursillo Weekend Retreat**
Description of Activity: Overnight Cursillo Retreat starting Thursday evening and ending on the following Sunday Afternoon. Activities include attending talks and liturgical events, having meals and walking between sleeping areas to meeting rooms, dining rooms, etc. Some staircases but options for ramps exist.	
Waiver Authorization	
FORM MUST BE COMPLETED IN ALL RESPECTS, SIGNED AND DATED TO AUTHORIZE THE WAIVER.	
I HOLD THE RETREAT HOUSE IDENTIFUIED ABOVE, SAN JOSE CURSILLO MOVEMENT AND DIOCESE OF SAN JOSE HARMLESS FROM ANY CLAIM OF INJURY, SICKNESS, ILLNESS OR DAMAGE THAT I MAY SUFFER OR SUSTAIN DURING THE ACTIVITY LISTED ABOVE, WITH EXCEPTION TO INJURY OF DAMAGES ARISING OUT OF THE SOLE NEGLIGENCE OF THE RETREAT HOUSE IDENTIFIED ABOVE THE SAN JOSE CURSILLO MOVEMENT OR DIOCESE OF SAN JOSE. *I ATTEST THAT I AM PHYSICALLY FIT TO PARTICIPATE IN THIS EVENT.* *IN THE EVENT I BECOME ILL OR INJURED, I DO HEREBY CONSENT TO WHATEVER X-RAY, EXAMINATION, MEDICAL OR TREATMENT AND HOSPITAL CARE ARE CONSIDERED NECESSARY IN THE BEST JUDGEMENT OF THE ATTENDING PHYSICAIN AND PERFORMED BY OR UNDER THE SUPERVISOIN OF A MEMBER OF THE MEDICAL STAFF OF THE HOSPITAL FACILITY PROVIDING THE TREATMENT.* *I AM NOT AWARE OF ANY MEDICAL CONDITION WHICH WOULD RENDER IT INAPPROPRIATE FOR ME TO PARTICIPATE IN ANY SUCH ACTIVITY.*	
Participant Signature:	Date Signed:
Internal Use Only	
Waiver Received By:	Date Received:

Updated 07/01/2018

The Chancery ● 1150 North First Street ● Suite 100 ● San Jose, California 95112-4966
(408) 983-0250 ● www.dsj.org ● Fax (408) 983-0296

Medical Information (for EMT use in case of Emergency)

Name:							
Height:		Weight:		Blood Pressure:		Resting Pulse (if Known)	

Allergies	☐Penicillin ☐Aspirin ☐Latex ☐Sulfa ☐ Other Drug Allergies: ______ ☐ Other Allergies: ______ ☐ I carry an Epi Pen with me for serious allergies ______ (Use a separate sheet if required.)
Medical Conditions	☐ Recent Illness? ______ ☐ Recent Hospitalizations or Operations: ______ ☐ Asthma: ☐ Use an Inhaler ☐ Diabetes: ☐Type 1 ☐Type 2 ☐Use Insulin ☐ High Blood Pressure ☐ Lung Disease ☐ Heart Condition: ☐ Pacemaker ☐ Medication ☐ Hearing Loss ☐ Impaired Vision: ☐ Contacts ☐ Glasses ☐ I am pregnant ☐ Have you ever had a seizure? ☐ Yes ☐ No ☐ Cancer (type): ______ ☐ Other: ______ (Use a separate sheet if required.)

Please list all prescription, over-the-counter, and natural mediations you are taking.

Medication Name	**Dosage**	**Frequency**	**Reason for Taking**

(Use a separate sheet or space below, if required, to list medications.)
Please provide further information for any Allergy or Medical Condition you identified.

When completed and signed place the form in an envelope, seal the envelope and write your name and the words "Medical Form" on the envelope. The envelope should be turned in at the Thursday evening check in for the Cursillo Weekend. The unopened envelope will be returned to you on Sunday.