Our Lady of Mount Carmel Appalachia Trip, June 22-29, 2024
HOLD HARMLESS AND INDEMNIFICATION AGREEMENT

This Agreement must be read and signed by each participant and returned to Our Lady of Mount Carmel staff prior to the trip to participate.

Printed Name of Participant: _____

Address, City, State, Zip: _____

Home Phone: _____

Emergency Contact & Phone: _____

IN CONSIDERATION of my participation in the Our Lady of Mount Carmel Parish Appalachia Trip in June of 2024, INTENDING TO BE LEGALLY BOUND HEREBY, I represent, convent, and agree, on behalf of myself and my personal representatives, assigns, heirs, next of kin, and any other person claiming, by under, or through me, as follows:

1. AGREE to participate in the Appalachia Trip with Our Lady of Mount Carmel Parish on June 22-24, 2024.
2. AGREE TO INDEMNIFY AND HOLD HARMLESS, Our Lady of Mount Carmel Parish Charitable Trust, the pastor/administrator of said parish and all of its sponsored programs, as well as all of its employees, agents and volunteers, and also the Roman Catholic Diocese of Pittsburgh and the Roman Catholic Diocese of Pittsburgh Charitable Trust, Most Reverend David A. Zubik, in his capacity as Bishop of the Diocese and as Trustee for the Parish, his successors and legal representatives and agents against any loss from any and all claims, demands and actions at law or in equity that may hereafter at any time be brought by me, or anyone acting on my behalf, for the purpose of enforcing a claim for damages because of any injury (including death) to me as a result of, or in any way related to my participation in the above mentioned trip, or my transit thereto.
3. In the event of injury or illness to me during the above trip, I hereby authorize hospital staff members to administer emergency medical treatment to me in the event I am incapacitated due to injury or illness during the trip. With regard to such treatment:
    a. I hereby indemnify and hold harmless any representative of Our Lady of Mount Carmel Parish Charitable Trust from any and all claims, demands, and causes of action of whatever kind and nature for their actions taken pursuant to this authority.
    b. I agree that in case of illness or injury to me, I will apply my hospitalization and/or accident insurance toward the payment of the expenses incurred and will not look to Our Lady of Mount Carmel Parish, the Roman Catholic Diocese of Pittsburgh, or their respective Pennsylvania Charitable Trusts for the payment of any medical or injury-related costs.

IN WITNESS WHEREOF, I execute this Hold Harmless and Indemnification Agreement the _____ day of _____, 2024.

_____

Signature

CONSENT TO TREAT

In the event I am incapacitated, I _____, an adult, do hereby authorize treatment of me by a licensed medical physician in case of any accident of illness that so arise, or any hospitalization necessary.

Signature
Date: _____
This consent will remain effective until 48 hours after the trip.

Medical Information

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, I am in good health, and I assume all responsibility for my health. Of the following statements pertaining to medical matters, SIGN ONLY THOSE IN ACCORDANCE WITH YOUR WISHES.

Participant Name: _____

Date of Birth: _____

Medications: I am taking the following medications at present:

(I will bring all such medications necessary, and such medications will be well labeled. I will administer my own medication.)

Do you have any reactions to bee, hornet or wasp stings?
_____

Any known allergies? _____

Any medical restrictions that would prevent you / your minor child from performing service on sites?
_____

Are you or your minor child subject to chronic homesickness, emotional reactions to new situations, or fainting?
□ YES □ NO

Any medically prescribed dietary needs: _____

Are you a vegetarian? □ YES □ NO

Are you allergic to any medication? _____

Immunization

Tetanus: _____

Insurance Information

Name of family physician: _____

Physician's Phone number: _____

Name of Insurer: _____

Policy Number: _____

Policyholder Name: _____

Policyholder's Employer: _____