2026 Holy Spirit Mission Trip
May 31-June 5, 2026

In cooperation with Christian Appalachian Project

ADULT Agreement & Medical Release Form

(Please type or print in ink all information, except signatures and complete both sides of this form.)

First Name _____ Middle Initial _____ Last Name _____

Address _____ Date of Birth (mm/dd/yy) _____

City, State, Zip _____

Phone _____

Emergency Contact Name _____ Phone _____

Safe Environment Protection Agreement

I hereby confirm that I have reviewed the updated the Diocesan Safe Environment Policy (SEP) and have electronically signed the form from the revised SEP, been fingerprinted, participated in the VIRTUS training in-service (and any necessary updates) and am in full compliance with the SEP of the Diocese.

Signature: _____ **Date:** _____

Adult Agreement

I understand that my participation in this program requires compliance with specific guidelines, rules and regulations as set forth by the parish and the diocese. I agree to abide by all rules and regulations set forth. Any infraction of the rules or regulations, including, but not limited to, the possession of alcohol, drugs, or weapons may cause my dismissal from the program. I am to be a role model for the youth. I am also responsible for holding the youth to the Contract of Expectations to which they agreed during the program.

Signature: _____ **Date:** _____

Media Agreement

I am aware that information about the trip (including participant's names) may periodically be included in parish, local, and/or diocesan publications. I am aware that photographs and video may be taken during portions of this event and approve use for parish and diocesan related purposes.

Signature: _____ **Date:** _____

Medical Information *(Please check and sign ONLY those in accordance with your wishes.)*

Select this:

☐ In the event of an emergency, I hereby grant permission to and obtain emergency medical or surgical treatment from a licensed physician, hospital, or medical clinic. I hereby authorize medical personnel to release necessary information about my care to group leaders Mark Violand and Anne Weeks of Holy Spirit Parish.

☐ If I am rendered unconscious for some reason, I wish to have the following person advised prior to further treatment by the hospital or doctor.

Name: _____ Phone: _____

Relationship to you_____

Family physician _____ Phone _____

(*Please check one of the following)*

☐ I am covered by hospitalization and medical insurance under policy # _____ issued by _____.

☐ I do not have medical coverage and/or I assume responsibility for the cost of hospitalization and medical care for myself.

Signature: _____ Date: _____

Or this:

☐ I hereby warrant that to the best of my knowledge, I am in good health. **I do not want <u>any</u> medical treatment to be given to me under any circumstances.** I hereby assume all responsibility for the health and well- being of myself and release from responsibility the Bishop of the Diocese of Youngstown, and Holy Spirit Parish, and the agents, associates, and employees of the Bishop and parish who have organized or participated in the supervision of such program.

Signature: _____ Date: _____

☐ I am taking medications at present. I will bring all such medications necessary and such medications will be well-labeled. The names of and the concise directions for taking such medications, including dosage and frequency of dosages are as follows:_____

_____

_____

Signature: _____ Date: _____

☐ I wish to inform you of the following additional medical information and the recommended course of action (allergies, dietary restrictions, special conditions, current medications, etc.)

_____

_____

_____

Signature:_____Date: _____