DeMolay Permission, Release and Indemnity – Person over 18

The undersigned grants permission to the use of information on this form, at the discretion of any advisor or adult volunteer of DeMolay to see that care or attention is given to my health.

My Name: _____ Date of Birth: _____

Address: _____ City: _____State: _____ Zip: _____

My Phone: (___) _____ Cell: (_____) _____

List any medications needed:

Do you have any physical, mental or emotional conditions that would prevent you from participating in activities? ☐ If so, please explain:

Do you have any reaction to drugs, food, insect bites, etc.? ☐ If so, please provide information on reaction and treatment

Emergency Contact: Name: _____Relationship:_____

Phone: (___) _____ Cell: (_____) _____

Family Practice MD Name: _____ Phone: (_____) _____

Insurance: Carrier: _____

Policy No.: _____Group No.:_____ Member No.: _____

If I am under age 21, I grant to any DeMolay advisor or adult volunteer authority to exercise supervision over me during the time I am going to or from or participating in a DeMolay chapter or jurisdiction activity or event.

If I am under age 21, I agree that, if deemed appropriate by a DeMolay advisor having supervisory authority at the activity or event: (1) my room may be entered, (2) I may be removed from any activity or event and/or (3) I will return home at my own expense.

I hereby release any DeMolay chapter, jurisdiction advisor and adult volunteer from any liability caused by me.

If I am unable to make informed decisions by myself, I authorize any DeMolay advisor or adult volunteer to obtain for me whatever medical services, including hospital and physician(s), such DeMolay advisor or adult volunteer determines appropriate as a result of injuries to or illness of me at the DeMolay activity or event or going to or from such activity or event.

I agree to pay the DeMolay chapter, jurisdiction, advisors or adult volunteers for any monies or credit advanced by any of them for such purposes and to indemnify and hold harmless said DeMolay chapter, jurisdiction, advisor or adult volunteer for medical expenses arising from any medical bills or medical expenses arising from any such medical aid rendered to or for me.

Signature: _____ Date: _____