# Diocese of La Crosse
# Child Comprehensive Medical Release & Permission Form

## Contact Information

Name:_____ Date of Birth: _____ __ Male _ Female

Parish Name/City:_____ Year of Graduation: _____

Address:_____ City:_____ State:_____ Zip: _____

Phone #:_____ (Home) E-mail Address: _____

Mother's name:_____ Phone: (H)_____ (W)_____ (C)_____

Father's name:_____ Phone: (H)_____ (W)_____ (C)_____

Emergency Contact:_____ Relationship: _____

Phone: (H)_____ (W)_____ (C)_____

Physician:_____ Clinic/Hospital:_____ Office Phone: _____

Medical Insurance Company:_____ Policy #: _____

## Medical History

If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability, or condition to which the participant is subject and of which the staff should be aware, and what, if any action of protection is required on account thereof. Submit this notification in writing and attach it to this form. Include names of medications and dosages that must be taken. The parish/Diocese of La Crosse will take reasonable care to see that the following information will be held in confidence. Some activities may be physically strenuous (especially mission trips and camps). If you desire to limit a participant's participation in any way, please submit your wishes in writing prior to the trip.

1. Is the participant in good health and able to participate in normal activities? _ Yes _ No
   If not, please submit a statement indicating limitations and/or restrictions.

2. Please give the date of the participant's most recent physical examination: _____

3. Immunization History (Please give dates)
   Date of last Tetanus Shot: _____
   *Please fill in below only for foreign mission trips:*
   DPT _____ DPT Booster _____ Polio Booster _____ Polio Series _____

   Other, if any necessary, for specific trip: _____
   *Note: You are responsible for consulting your doctor about immunizations necessary for foreign missions.

4. Allergies
   Pollens _____ Medications _____ Food _____ Insect bites _____

   Please note specifics: _____

5. Has the participant ever suffered from or been treated for any of the following:
   Asthma_____ Diabetes _____ Epilepsy/seizure disorder _____ Heart trouble _____ Physical handicap_____ Other _____
   Frequently upset stomach _____
   Depression _____ Emotional/Mental Disorder _____

## Medical Treatment

*Emergency Medical Treatment*: In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment at my expense. I wish to be advised prior to any further treatment by the hospital or doctor. In the event that you are unable to reach me, such treatment may be administered if deemed necessary. In the event of an emergency, if you are unable to reach me at the numbers given above, please contact the emergency contact listed above.

Initials of Parent Guardian:_____ Date: _____

*Other Medical Treatment*: In the event it comes to the attention of the parish, its officers, directors and agents, and the Diocese of La Crosse, chaperones, or representatives associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called collect (with phone charges reversed to myself).

Initials of Parent Guardian:_____ Date: _____

*Medications*: My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows: _____

Initials of Parent Guardian:_____ Date: _____

No medication of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life-threatening and emergency treatment is required.

**OR**

I hereby grant permission for non-prescription medication (such as aspirin products, i.e. acetaminophen or ibuprofen, throat lozenges, cough syrup) to be given to my child if deemed appropriate.

Initials of Parent Guardian:_____ Date: _____

## Code of Conduct

We expect each participant to conform to these rules of conduct:

No possession or use of alcohol, drugs, tobacco, or pornography.
No fighting, weapons, fireworks, lighters, or explosives.
No offensive or immodest clothing.
No student may drive.
No males in female sleeping quarters, and no females in male sleeping quarters.
Participation with the group is expected.
Respect property.
Respect one another, staff, and leaders.
Respect and comply with event schedules and with any other specific event rules established by leaders.

**Students who fail to comply with these expectations may be sent home at their parents' expense.**

I, the student, have read the rules of conduct, the above evaluation of my health, and permission to participate in youth group activities. I agree to abide by the stated personal limitations and code of conduct.

Initials of Student:_____ Date: _____

Initials of Parent Guardian:_____ Date: _____

## Permission to Use Participant Photos

You have my permission to use said participant's photos for commercial purposes (ex: advertising this event in flyers, on the web, etc.).

Initials of Student:_____ Date: _____

Initials of Parent Guardian:_____ Date: _____

## Statement of Truth and Accuracy

I hereby certify that all of these statements are true and accurate to the best of my knowledge.

Signature of Parent/Guardian:_____ Date: _____

Signature of Student:_____ Date: _____

Initials of Parent Guardian:_____ Date: _____