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

## Contact Information

Name:_____ DOB: _____ M F

Parish Name/City: _____Year of St. Joseph Graduation_____

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

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

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

Emergency Contact: _____ Relationship: _____

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

Physician: _____ Clinic/Hospital: _____ Phone:_____

Medical Insurance Company: _____ Policy Number: _____

Dentist: _____ Clinic: _____ Phone: _____

## 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. 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? Y N
   If no, 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) It is the parents' responsibility to make sure the school office has the most recent immunization record for the participant.
   Date of last Tetanus Shot: _____
4. Allergies: Pollens _____ Medications _____ Food _____ Insect bites _____ Other _____
   Please note specifics: _____
5. Has the participant ever suffered from or been treated for anything of the following:
   Asthma _____ Epilepsy/seizure disorder _____ Heart Trouble _____ Diabetes _____ Depression _____
   Physical Handicap _____ Frequently upset stomach _____ Emotional/Mental Disorder _____
   Other (please explain): _____
6. Operations, serious injuries, or major illnesses in the past year: _____
   _____ Dates: _____
7. Is the participant subject to chronic homesickness, emotional reactions to new situations (sleepwalking, bedwetting, fainting)? _____
8. Has the participant recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc?
   If so, list date and disease/condition: _____
9. Does the participant have a medically prescribed diet? Y N If yes, attached diet information.
10. The participant is a ____ swimmer ____non-swimmer.
11. Does the participant use an inhaler? Y N Does the participant use an epipen? Y N

**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: _____

***Medications:*** My child is taking medication at present. My child will bring in all such medications in its original container when necessary. The parent/guardian will fill out the St. Joseph Prescription or Non-Prescription Drug Form to be kept on file in the office. I know these forms must be completed and in the office before school employees can administer the medication.

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: _____

Initials of Parent/Guardian: _____ Date: _____

**Code of Conduct**

We expect each student and family at St. Joseph School to follow 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.

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 of code and conduct.

Initials of Student: _____ Date: _____

Initials of Parent/Guardian: _____ Date: _____

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: _____