

Diocese of La Crosse
Adult Comprehensive Medical Release & Permission Form

Contact Information

Name _____ Date of Birth _____ Male Female
 Parish Name/City _____
 Address _____ City _____ State _____ Zip _____
 Phone #: Home _____ Work _____ Cell _____
 Email Address _____
 Emergency Contact _____ Relationship _____
 Phone #: Home _____ Work _____ Cell _____
 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 you are 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. 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 your participation in any way, please submit your wishes in writing prior to the trip.

1. Are you 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 your 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. Have you ever suffered from or been treated for any of the following?

Asthma _____	Epilepsy/seizure disorder _____	Heart trouble _____
Diabetes _____	Frequently upset stomach _____	Physical Handicap _____
Depression _____	Emotional/Mental Disorder _____	Other _____
6. Operations, serious injuries, or major illnesses in the past year?
 _____ Dates _____
7. Have you recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc.?
 If so, list date and disease or condition _____
8. Do you have a medically prescribed diet? Yes No
9. You are a swimmer Non- swimmer

Medical Treatment

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport me to a hospital for emergency medical or surgical treatment at my expense. In the event of an emergency, please contact the emergency contact listed above.

Initials: _____ Date: _____

Permission to Use Participant Photos

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

Initials: _____ 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: _____ Date: _____