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 #s: (Home) _____ (Work) _____ (Cell) _____

E-mail Address: _____

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 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: _____