

Confirmation Retreat Permission Form – Please return by Wednesday, March 1st.

Diocese of La Crosse
Child Comprehensive Medical Release & Permission Form

Contact Information

Name: _____ Date of Birth: ____/____/____ Male Female
Parish Name/City: Saint Therese of the Child Jesus Parish, Rothschild 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: _____
Emergency Contact 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 _____ 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. 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 or condition: _____
9. Does the participant have a medically prescribed diet? Yes No
10. The participant is a swimmer non-swimmer

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: ____/____/____

Initials of Parent/Guardian: _____ Date: ____/____/____

Parental/Guardian Consent and Liability for Minors

I, _____, grant permission for my child, _____ to participate in this
Parent or Guardians Name Child's Name
diocesan/parish event. This activity will take place under the guidance and direction of diocesan/parish employees and/or volunteers from Saint Therese of the Child Jesus Parish.

A brief description of the activity follows:

Type of activity: Confirmation Retreat at St. Therese on May 13, 2023

Individuals in Charge: Dcn. Mike Lambrecht & Joy Orozco

As parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above named minor ("participant"). I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend Saint Therese Parish, its officers, directors, employees and agents, and the Diocese of La Crosse, its employees and agents, chaperones, or representatives associated with the event, from any claim arising from or in connection with my child attending the event or in connection therewith, and I agree to compensate the parish, its officers, directors and agents, and the Diocese of La Crosse, its employees and agents and chaperones, or representative associated with the event for reasonable attorney's fees and expenses which may incur in any action brought against them as a result of such injury or damage, unless such claim arises from the negligence of the parish/diocese.

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.

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: ____/____/____

Please include a payment of \$25 to cover the cost of the retreat.

If you are unable to pay due to financial hardship,
contact Dcn. Mike at 715-298-7366.

Please make Checks out to *St. Therese Parish*.

____ Cash ____ Check # ____