Diocese of La Crosse
Adult Comprehensive Medical Release & Permission Form

Contact Information

Name: _____ Date of Birth: _____ ☐ Male ☐ Female

Parish Name/City: St. Ladislaus Parish/Bevent

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: _____

DIOCESE OF LA CROSSE
CONFIDENTIAL EMPLOYEE AND VOLUNTEER QUESTIONNAIRE

THIS FORM MUST BE COMPLETED BY ALL EMPLOYEES, VOLUNTEERS, GROUP LEADERS, CHAPERONS AND DRIVERS.

Name:_____
Last First Middle

Address:_____
Street

_____
City State Zip

Telephone:_____
Home Business

Sexual misconduct by personnel (including officers, employees, lay volunteers, clerics, and religious personnel) of the Diocese of La Crosse while performing the work of the Diocese of La Crosse is contrary to Christian principles and is outside the scope of the duties and employment of all personnel.

Has a civil or criminal complaint ever been filed against you alleging drug, alcohol, physical or sexual abuse or misconduct? Yes_____ No_____

If yes, give a short explanation of the complaint. (Please indicate the date, nature, and place of the incident leading to the complaint, where the complaint was filed, and the disposition of the complaint). _____

_____

_____

Have you ever terminated your employment or had your employment terminated for reasons relating to allegations of drug, alcohol, physical or sexual abuse or misconduct? Yes_____ No_____

If yes, give a short explanation of the allegations. (Please indicate the date, nature, and place of the allegations, the dispositions of the allegations, and your employer at the time (including your employer's name, address, and telephone number.)

_____

_____

_____

Have you ever received any medical treatment, physical or psychological, for reasons involving drug, alcohol, physical or sexual abuse or misconduct? Yes_____ No_____

If yes, give a short description of the treatment, including date(s), nature, and location(s), identifying the treating physician with name, address and telephone number. _____

_____

_____

_____

List three persons who can provide character references relating to your fitness for working with young people. These should not be family members or past or present employers.

Name: _____ Home phone: _____

Street Address: _____

City/State/Zip: _____

Name: _____ Home phone: _____

Street Address: _____

City/State/Zip: _____

Name: _____ Home phone: _____

Street Address: _____

City/State/Zip: _____

The information provided in this form is correct to the best of my knowledge. I understand that in signing this document, I authorize verification of this information through communication with any person or organization named herein. I release from liability any person or organization which provides such information, as well as the Diocese of La Crosse and the Parish of _____.

_____
Print name

_____
Signature

_____
Date