COMPREHENSIVE RELEASE & MEDICAL FORM FOR MINOR

Annual Minor Participant Release and Medical Form
Please fill out this form for anyone who is age 18 (still in high school) and under.

PARISH/SCHOOL: _____ **CITY:** _____

CONTACT INFORMATION

PARTICIPANT: _____ **DATE OF BIRTH:** _____ ☐ **MALE** ☐ **FEMALE**

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

MOBILE PHONE: _____ **HOME PHONE:** _____

EMAIL: _____

MOTHER'S NAME: _____

MOBILE PHONE: _____ **HOME PHONE:** _____

EMAIL: _____

FATHER'S NAME: _____

MOBILE PHONE: _____ **HOME PHONE:** _____

EMAIL: _____

IF UNABLE TO REACH A PARENT/GUARDIANS AT THE ABOVE NUMBERS, CONTACT:

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____

MOBILE PHONE: _____ **HOME PHONE:** _____

MEDICAL CONTACT INFORMATION

HOSPITAL/CLINIC: _____

PHYSICIAN: _____ **PHONE:** _____

MEDICAL INSURANCE COMPANY: _____ **POLICY #:** _____

PARENTAL/GUARDIAN CONSENT AND LIABILITY FOR MINORS

As parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above-named PARTICIPANT.

I agree on behalf of myself, my child "PARTICIPANT", or our heirs, successors, and assigns, to hold harmless and defend the above "PARISH/SCHOOL", its officers, directors, employees, chaperones, and agents, and the Diocese of La Crosse, its officers, directors, employees, chaperones, and agents from any claim arising from or in connection with PARTICIPANT's attendance, enrollment or participation in the program, school, activity or event or in connection with any illness or injury (including death) or cost of medical treatment in connection therewith, and agree to compensate the PARISH/SCHOOL, its officers, directors, employees, chaperones, and agents and the Diocese of La Crosse, its officers, directors, employees, chaperones, and agents associated with the PARTICIPANTS attendance, enrollment or participation on the program, school, activity or 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, whether such claim arises from the alleged negligence of the PARISH/SCHOOL, its officers, directors, employees, chaperones, and agents, and the Diocese of La Crosse, its officers, directors, employees, chaperones, and agents negligence. If any portion of this agreement is held invalid, it is agreed that the balance thereof, shall continue in full legal force and effect.

SIGNATURE: _____ **DATE:** _____

PERMISSION TO USE PARTICIPANT PHOTOS

You have my permission to use said photos for commercial purposes (ex. flyers, on the web, etc.)

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

PARTICIPANTS SIGNATURE: _____ **DATE:** _____

CODE OF CONDUCT

Each PARTICIPANT is expected to comply with the following rules of conduct, in addition to any additional rules or code of in place by Parish/School:

- No possession or use of alcohol, drugs, tobacco, vaping, or pornography.
- No fighting, weapons, fireworks, lighters or explosives.
- No offensive or immodest clothing.
- Participation with the group is expected.
- Respect property.
- Respect one another, staff, and leaders.
- Respect and comply with schedules and with other specific rules established by leaders.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

PARTICIPANTS SIGNATURE: _____ **DATE:** _____

STATEMENT OF TRUTH AND ACCURACY

I have read the rules of conduct, and permission to participate in Parish/School activities. I agree to abide by the personal limitations and code of conduct. I hereby certify that all of these statements are true and accurate to the best of my knowledge.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

PARTICIPANTS SIGNATURE: _____ **DATE:** _____

MEDICAL HISTORY/INFORMATION

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, treatment may be administered if deemed necessary. In the event of an emergency, if you are unable to reach me at the numbers given, please contact the emergency contact listed above.

☐ **Yes** ☐ **No**

Medications: list all medications, prescriptions & over-the-counter, the Participant currently takes at home and during the school day. Include all as-needed and emergency medications. Medications not authorized for self-carry must be in the original container & given to the designated supervisor.

MEDICATION	DOSAGE	HOW GIVEN	FREQUENCY	START DATE	STOP DATE	SIDE EFFECTS

(If necessary, list other medications on another sheet of paper.)

Other Medical Treatment: In the event that my child becomes ill with symptoms such as headache, vomiting, sore throat, or fever, do you grant permission for leaders to give your child non prescription medication, such as acetaminophen, throat lozenges, cough syrup, or antacid?

☐ **Yes** ☐ **No** ☐ **I wish to be contacted first.**

I authorize the Parish/School to give the above prescription medication(s) to this PARTICIPANT.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

Inhaler and Epi-Pen ONLY: This PARTICIPANT and his/her parents have been instructed in self administration and the student may carry an inhaler or Epi-Pen and self administer.

☐ **Yes** ☐ **No**

Does the PARTICIPANT have any dietary restrictions/considerations?

☐ **Yes** ☐ **No**

If the PARTICIPANT has a medically prescribed diet, please list the details below:

_____

ALLERGIES: (Please check all that apply): ☐ **Pollen** ☐ **Medications** ☐ **Insect Bites** ☐ **Food**

Please specify: _____

Treatment History: (Please check all that apply)

☐ Asthma ☐ Diabetes ☐ Epilepsy/Seizure Disorder ☐ Frequent upset stomach ☐ Heart Trouble

☐ Physical Handicap ☐ Depression Emotional/Mental Disorder ☐ Other

Details:_____

_____

Operations, serious injuries, or major illness in the past year: _____

_____ Dates: _____

PARENT CONSENT FOR MEDICAL TREATMENT AND ADMINISTRATION OF MEDICATION

I hereby warrant that to the best of my knowledge, my child (PARTICIPANT) is in good health and assume all responsibility for the health of my child. I give the school/parish permission for emergency and other medical treatment, including the administration of the above prescription(s) and non-prescription medication(s).

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

Inhaler/Epi-Pen Only: ☐ My child may ☐ My child may not carry a medically prescribed Inhaler/epi-pen.

STATEMENT OF TRUTH AND ACCURACY

I have read the above health evaluation and give my permission for my child to participate in Parish/School activities. I hereby certify that all of these statements are true and accurate to the best of my knowledge.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____