

**St. Therese/Diocese of La Crosse**

**General Child Release Form**

Student's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Sex \_\_\_\_\_

Parent/Gaurdian's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Cell \_\_\_\_\_

**PARENTS... Would you be interested in helping with this event as a driver or chaperone? Yes \_\_\_\_\_ No \_\_\_\_\_**

**Would you be interested in helping with future events? Yes \_\_\_\_\_ No \_\_\_\_\_**

**Event: Teen Lock In from Fri 1/20/12 – Sat 1/21/12 (7pm to 7am)**

I, \_\_\_\_\_, grant permission for my child, \_\_\_\_\_, to participate  
Parent/Guardian's Name Student's Name  
in this parish event. This activity will take place under the guidance and direction of parish employees and/or volunteers from St. Therese Parish.

As parent or legal guardian, I remain legally responsible for any personal actions taken by the above named minor (student).

I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend St. Therese Parish, its officers, directors, employees and agents, and the Diocese of La Crosse, its employees and agents, chaperons, or representatives associated with the event, from any claim arising from or in connection with my child attending the event or in connection with any illness or injury (including death) or cost of medical treatment in connection therewith, and I agree to compensate the parish, its officers, directors and agents, and the Diocese of Lacrosse, its employees and agents and chaperons, or representative associated with the event for reasonable attorney 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.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE FILL OUT THE MEDICAL INFORMATION ON THE REVERSE SIDE**

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child. (Of the following statements pertaining to medical matters, sign only those that are applicable.)

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. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Name and Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Health Plan Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

Signature: \_\_\_\_\_ 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).

Signature: \_\_\_\_\_ 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:

\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ 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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby grant permission for non-prescription medication (such as non-aspirin products, i.e. acetaminophen or ibuprofen, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

SPECIFIC MEDICAL INFO: The parish will take reasonable care to see that the following information will be held in confidence.

Allergic reactions (medications, foods, plants, insects, etc.): \_\_\_\_\_

Immunizations: Date of alst tetanus/diphtheria immunization: \_\_\_\_\_

Does the child have a medically prescribed diet? \_\_\_\_\_

Any physical limitations? \_\_\_\_\_

Is the child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, or fainting? \_\_\_\_\_

Has the child recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc.? If so, list the date and disease or condition: \_\_\_\_\_

You should be aware of these special medical conditions of my child: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_