


HOLY CROSS SEMINARY HOUSE OF FORMATION

P.O. BOX 4004, LA CROSSE, WI 54602-4004
(608) 788-9095 • DIRECTOR@HOUSEOFFORMATION.COM

COMPREHENSIVE CHILD CONSENT & RELEASE FORM

Name of Applicant: _____

Parent/Guardian's Name: _____

Address: _____

Telephone: (home) _____ (work) _____

I, _____ (parent/guardian name), grant permission for my child, _____ (child's name), to participate in the Holy Cross Seminary House of Formation, that in addition may require transportation to locations away from the Diocesan site. This activity will take place under the guidance and direction of Diocesan employees and/or volunteers from the Diocese of La Crosse.

As parent/legal guardian, I remain legally responsible for any personal actions taken by the above-named minor ("participant").

As a condition of my child's participation in the Holy Cross Seminary House of Formation, I agree on behalf of myself, my child named herein, or our heirs, successors and assigns, to hold harmless and defend the Holy Cross Seminary House of Formation, its officers, directors, employees and agents, and the Diocese of La Crosse, its employees and agents, chaperones or representatives associated with the Holy Cross Seminary House of Formation, from any claim arising from or in connection with my child attending the Holy Cross Seminary House of Formation or in connection with any illness or injury (including death) or cost of medical treatment in connection therewith, and I agree to compensate the Holy Cross Seminary House of Formation, its officers, directors and agents, and the Diocese of La Crosse, its employees and agents and chaperones, or representatives associated with the Holy Cross Seminary House of Formation 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 Holy Cross Seminary House of Formation.

Signature: _____ Date: _____


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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: _____ Phone: _____

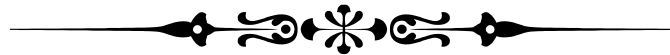
Relationship: _____

Family Doctor: _____ Phone: _____

Family Health Plan Carrier: _____

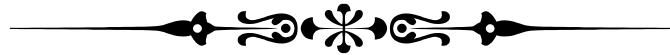
Policy #: _____

Signature: _____ Date: _____



Other Medical Treatment: In the event it comes to the attention of the Holy Cross Seminary House of Formation, its officers, directors and agents, and the Diocese of La Crosse, chaperones or representatives associated with the Holy Cross Seminary House of Formation 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 me).

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: _____


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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: _____



Special Medical Information: The Holy Cross Seminary House of Formation 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 last tetanus/diphtheria immunization: _____

Does child have a medically-prescribed diet? _____

Any physical limitations? _____


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Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bed-wetting, fainting? _____

Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chicken pox, etc.? If so, give date and disease or condition: _____

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

Signature: _____ Date: _____