

Adult Registration and Medical Release (18 years old to adult)
Come & See Days / Come, Follow Days / Discernment Retreat / Formation Weekends
Mater Redemptoris Convent and House of Formation



Cost: Free (Donations accepted)
 (Checks made payable to: Mater Redemptoris)

Please **send** your registration / permission form to:
 Mater Redemptoris Convent and House of Formation
 PO Box 4004
 La Crosse, WI 54602-4004

Name: _____ Date of Birth: _____

Home Address: _____ City: _____

State: _____ Zip: _____ E-mail Address: _____

Phone: (H) _____ (W) _____ (C) _____

Name of Parents: (F) _____ (M) _____

Emergency Contact: _____ Relationship: _____

Phone: (H) _____ (W) _____ (C) _____

E-mail Address: _____

Parish Name/City: _____ Grade (in Fall): _____

Name of school, attending: _____

City/State of School: _____

Physician: _____

Clinic/Hospital: _____ Office Phone: _____

Medical Insurance Company: _____

Policy #: _____ Group #: _____

<i>For office use only:</i>		
Cash	Amt: _____	Date: _____
Ck # _____	Amt: _____	Date: _____
Ck # _____	Amt: _____	Date: _____
Notes: _____		

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: _____

4. Allergies: Pollens _____ Medications _____ Food _____ Insect bites _____ Other: _____

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, Diocesan newspaper (*Catholic Times*, 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: _____