

**Extreme Faith Camp 2010
Jr. High Registration Form
Church of St. Albert and St. Michael Catholic Church**

PARENTAL/GUARDIAN CONSENT AND LIABILITY WAIVER

**THIS FORM IS TO BE HANDED INTO: Church of St. Albert: Cassandra Olson and
St. Michael Catholic Church: John O'Sullivan**

Participant's Name: _____
Home Address: _____
City: _____ **State/Zip:** _____ **Home Phone:** _____
Email: _____
Date of Birth: ___/___/___ **Gender:** ___ Male ___ Female **Grade in School** (Fall 2010): 7 8 9
Parent/Guardian's Name: _____ **Phone:** _____

Type/Date of Event: Extreme Faith Camp 2010 to be held at *Big Sandy Camp, McGregor, MN*
Location: Big Sandy Camp – McGregor, MN
Group Leader: *Cassandra Olson and John O'Sullivan*
Mode of Transportation: Bus / Car pool
Cost of Event: \$400.00 for Jr. High teens (\$100.00 deposit due w/t registration)
Early Bird Rate of \$350 if signed up before March 1st, Early Bird Rate of \$375 if signed up by April 1st!
T-Shirt Size: SM MED LG XL XXL XXXL

EMERGENCY MEDICAL TREATMENT: In the event of an emergency, I give permission to transport my child to a hospital. I agree to allow my child to receive emergency medical treatment at my expense at the discretion of the event sponsor. I wish to be advised prior to any further treatment by a doctor or hospital. In the event of any emergency, if you are unable to reach me at the above numbers, contact:

Name Relationship Phone Number

**HEALTH INFORMATION:
(Please Provide A Copy Of Your Medical Insurance Card)**

Medication my child is taking at present _____
 For headache or minor pain, my child may be given _____
 Allergies _____
 Other Medical Conditions _____
 Insurance Company _____
 Family Health Plan carrier number _____
 Family Doctor _____ Phone Number _____

I, _____, **GIVE PERMISSION FOR** _____
Parent or Guardian Name Child Name

TO PARTICIPATE IN THE ABOVE-DESCRIBED EVENT. I warrant that my child is in good health. In consideration of my child's participation, I agree to indemnify the *Church of St. Albert/St. Michael Catholic Church* from any claims or law suits brought by myself, my child, or others, that arises out of any behavior by my child at the event/activity described above. I also agree to pay reasonable attorney's fees or expenses incurred by the *Church of St. Albert/St. Michael Catholic Church* defense of such a claim/suit.

I agree to drop my child off at the departure location at least 15 minutes prior to departure and to provide transportation home at my expense.

I agree that I am responsible for my child's conduct and actions. The event sponsor is not responsible for any injury or damage incurred or caused by my child. I understand that my child is required to comply with the Code of Conduct provided by *Church of St. Albert/St. Michael Catholic Church* while participating in the event. I understand that if my child violates the Code of Conduct he/she may be required to be transported home at my expense.

Parent/Guardian Signature _____ Date _____

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.*)

Medical Treatment: In the event it comes to the attention of *Church of St. Albert/St. Michael Catholic Church*, its officers, directors and agents, and the Archdiocese of Saint Paul & Minneapolis, chaperons, 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 at my expense.

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 indicated on attached Prescription Drug & Medical Authorization Form.

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 Information: *Church of St. Albert/St. Michael Catholic Church* 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? _____

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

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

CODE OF CONDUCT

The following are a few rules that all participants are expected to follow while participating and representing the *Church of St. Albert/St. Michael Catholic Church*, in this event sponsored by the *Church of St. Albert/St. Michael Catholic Church June 21-25, 2010*.

Please read and sign.

I, _____, WILL:
Printed Name of Youth Participant

- Treat all other persons with respect and not cause any intentional harm (physically, emotionally, or spiritually) to any person in any way.
- Respect the property of others, including all program facilities and property.
- Follow all appropriate instructions of all personnel aiding in this event, including, but not limited to, chaperones, support staff, transportation personnel and administration.
- Be on time for all check-ins and departure time.
- Not have in my possession any tobacco, alcohol or any controlled illegal substance

I agree that if any of these terms are violated, the *Church of St. Albert/St. Michael Catholic Church* can send the participant home at the participant/guardian's expense.

Youth Participant Signature

Date

Parent/Guardian Signature

Date

Please return to:

Attn: Cassandra Olson

Church of St. Albert 11400 57th St. NE, Albertville, MN 55301

Or

Attn: John O'Sullivan

St. Michael Catholic Church, 11300 Frankfort Pkwy NE, St. Michael, MN 55376

By Monday May 3rd, 2010

(Registration for Extreme Faith Camp 2010 is closed after Monday May 3rd, 2010)

Church of St. Albert/St. Michael Catholic is sponsoring this activity is responsible for receiving an authorized form for each participant under the age of 18.

Church of St. Albert/St. Michael Catholic
PRESCRIPTION DRUG AND MEDICINE AUTHORIZATIONS
(USE THIS FORM ONLY IF MEDICATION IS TO BE GIVEN DURING THE EVENT)

Any prescriptions or over-the-counter medicine must be in the original, labeled container and stored under lock and key.

The following information must be completed before medicine is given.

Student Name _____

Name of Prescription/Medicine _____

Prescribing Doctor _____

Amount of Dosage _____

Times to be given _____

Duration of Prescription _____

I, _____, hereby authorize St. Albert/St. Michael to dispense
Parent /Guardian Name
medicine to _____ as directed above.
Participants Name

Signature of Parent/Guardian of Participant

Date

BIG SANDY YOUTH REGISTRATION / MEDICAL FORM

M F	
Camper name	
Address	
City	State Zip
Home Phone #	E-Mail Address
Grade	Age at Camp Birth date
Retreat/Camp Session	Date Year
Church Sponsoring, <i>if any</i>	
Parent or Guardian	Emergency Contact Person
Emergency Home Phone	Emergency Cell Phone
Health Insurance Company	
Insurance ID #	Group #
Physician's Name	Phone Number

HEALTH HISTORY— CHECK (X) THOSE THAT APPLY

- | | |
|---|--|
| <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> HEART TROUBLE |
| <input type="checkbox"/> CHICKEN POX | <input type="checkbox"/> SKIN TROUBLE |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> BED WETTING |
| <input type="checkbox"/> CONVULSIONS | <input type="checkbox"/> EAR TROUBLE |
| <input type="checkbox"/> EMOTIONAL PROBLEMS | |
- ALLERGIC TO:
- PENICILLIN
- INSECT STINGS
- OTHER (LIST)

IMMUNIZATION RECORD—CHECK (X) IF IMMUNIZED AGAINST.

- | | |
|-------------------------------------|---|
| <input type="checkbox"/> POLIO | <input type="checkbox"/> WHOOPING COUGH |
| <input type="checkbox"/> SMALL POX | <input type="checkbox"/> MEASLES |
| <input type="checkbox"/> DIPHTHERIA | <input type="checkbox"/> RUBELLA |
- Date of Last Tetanus Booster _____

LIST ANY ACTIVITY RESTRICTIONS, DIETARY RESTRICTIONS, HEALTH PROBLEMS AND/OR MEDICATION (RX OR OTC) RELATING TO YOUR CHILD. PLEASE GIVE A DESCRIPTION OF ANY CURRENT PHYSICAL, MENTAL, OR PSYCHOLOGICAL CONDITIONS REQUIRING MEDICATION, TREATMENT, OR SPECIAL RESTRICTIONS OR CONSIDERATIONS WHILE AT CAMP. USE THE REVERSE SIDE OR AN ADDITIONAL SHEET.

IMPORTANT

IF THE HEALTH HISTORY IDENTIFIES HEALTH PROBLEMS OR ACTIVITY LIMITATIONS, A PHYSICAL EXAMINATION MUST BE PERFORMED BY A LICENSED PHYSICIAN WITHIN ONE YEAR BEFORE ADMISSION TO CAMP, INCLUDING INSTRUCTIONS RELATIVE TO THE LIMITATION OF THE CAMPER'S PARTICIPATION IN CAMP ACTIVITIES OR MEDICATION REQUIREMENTS.

I UNDERSTAND THAT EVERY EFFORT WILL BE MADE TO PROTECT AND SAFEGUARD ALL GUESTS. I AGREE NOT TO HOLD BIG SANDY CAMP LIABLE FOR ANY ILLNESS OR MISHAP FROM ANY CAUSE WHATSOEVER.

I ALSO GIVE CAMP FULL AUTHORITY IN DEALING WITH CAMPER DISCIPLINE. I UNDERSTAND THAT ANY CAMPER DISREGARDING CAMP RULES IS SUBJECT TO BEING SENT HOME WITH NO REFUND OF CAMP FEES. I UNDERSTAND THAT ANY CAMPER WHO WILLFULLY DESTROYS PROPERTY WILL BE HELD RESPONSIBLE AND BE CHARGED ACCORDINGLY.

BIG SANDY CAMP MAY USE PHOTOS, VIDEO, OR COMMENTS, OF THE CAMPER NAMED ABOVE IN ITS PROMOTIONAL MATERIALS.

I GIVE PERMISSION TO BIG SANDY CAMP TO DISPENSE MEDICATION (RX OR OTC MEDICATION) TO MY CAMPER TO MANAGE ILLNESS AND INJURY AS DIRECTED BY THE BIG SANDY CAMP MEDICAL PROTOCOL.

IN CASE OF EMERGENCY, IF I CANNOT BE CONTACTED, OR THE EMERGENCY NUMBER CANNOT BE CONTACTED, I HEREBY GIVE PERMISSION TO THE PHYSICIAN SELECTED BY THE CAMP DIRECTOR TO HOSPITALIZE, SECURE TREATMENT FOR AND TO ORDER INJECTION, ANESTHESIA OR SURGERY FOR MY CHILD, AS NAMED ABOVE.

ALL ABOVE INFORMATION IS CORRECT AS LISTED.

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____