

**Extreme Faith Camp 2010 Jr. High Registration Form (CHURCH OF ST. BONIFACE)**

PARENTAL/GUARDIAN CONSENT AND LIABILITY WAIVER  
*THIS FORM IS TO BE HANDED INTO: Church of St. Boniface / Michelle Davis*

Type/Date of Event: Extreme Faith Camp 2010 to be held at *Big Sandy Camp, McGregor, MN*  
Locations: Big Sandy Camp – McGregor, MN  
Group Leader: *Michelle Davis*  
Mode of Transportation: Bus / Car pool  
Cost of Event: \$325.00 if registered by April 30 or \$375 after April 30 (\$125.00 deposit due w/ registration)  
T-Shirt Size: SM MED. LG. XL XXL XXXL

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: \_\_\_\_\_

**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. Boniface* 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. Boniface* in 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. Boniface* 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. Boniface*, 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: \_\_\_\_\_

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 Information: *Church of St. Boniface*, 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. Boniface*, in this event sponsored by the *Church of St. Boniface* 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. Boniface* can send the participant home at the participant/guardian's expense.

\_\_\_\_\_  
Youth Participant Signature Date

\_\_\_\_\_  
Parent/Guardian Signature Date

Please return to: *Church of St. Boniface* (Attn: *Michelle Davis*) – (St. Boniface Faith Formation  
*P.O. Box 276 St. Bonifacius, MN 55375*)

**By Friday April 30, 2010**

**(The price of camp increases to \$375.00 for registrations received after April 30)**  
**(Registration for Extreme Faith Camp 2010 is closed after Friday May 14, 2010)**

*Church of St. Boniface* is sponsoring this activity is responsible for receiving an authorized form for each participant under the age of 18.

**CHURCH OF ST. BONIFACE**  
**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.

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Student Name \_\_\_\_\_

Name of Prescription/Medicine \_\_\_\_\_

Prescribing Doctor \_\_\_\_\_

Amount of Dosage \_\_\_\_\_

Times to be Given \_\_\_\_\_

Duration of Prescription \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_ to  
Parent/Guardian Church of St. Boniface  
dispense medicine to \_\_\_\_\_ as directed above.  
Teen

\_\_\_\_\_  
Signature of Parent/Guardian Date

# BIG SANDY YOUTH REGISTRATION / MEDICAL FORM

<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;"></td> <td style="width: 20%; text-align: center;">M F</td> </tr> <tr> <td colspan="2">Camper name</td> </tr> <tr> <td colspan="2">Address</td> </tr> <tr> <td>City</td> <td style="text-align: center;">State Zip</td> </tr> <tr> <td>Home Phone #</td> <td style="text-align: center;">E-Mail Address</td> </tr> <tr> <td>Grade</td> <td style="text-align: center;">Age at Camp Birth date</td> </tr> <tr> <td>Retreat/Camp Session</td> <td style="text-align: center;">Date Year</td> </tr> <tr> <td colspan="2">Church Sponsoring, <i>if any</i></td> </tr> <tr> <td>Parent or Guardian</td> <td style="text-align: center;">Emergency Contact Person</td> </tr> <tr> <td>Emergency Home Phone</td> <td style="text-align: center;">Emergency Cell Phone</td> </tr> <tr> <td colspan="2">Health Insurance Company</td> </tr> <tr> <td>Insurance ID #</td> <td style="text-align: center;">Group #</td> </tr> <tr> <td>Physician's Name</td> <td style="text-align: center;">Phone Number</td> </tr> </table> <p><b>HEALTH HISTORY— CHECK (X) THOSE THAT APPLY</b></p> <table style="width: 100%;"> <tr> <td>EPILEPSY</td> <td>HEART TROUBLE</td> </tr> <tr> <td>CHICKEN POX</td> <td>SKIN TROUBLE</td> </tr> <tr> <td>ASTHMA</td> <td>BED WETTING</td> </tr> <tr> <td>CONVULSIONS</td> <td>EAR TROUBLE</td> </tr> <tr> <td>EMOTIONAL PROBLEMS</td> <td></td> </tr> </table> <p>ALLERGIC TO:</p> <p>PENICILLIN INSECT STINGS OTHER (LIST)</p>		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	EPILEPSY	HEART TROUBLE	CHICKEN POX	SKIN TROUBLE	ASTHMA	BED WETTING	CONVULSIONS	EAR TROUBLE	EMOTIONAL PROBLEMS		<p><b>IMMUNIZATION RECORD—CHECK (X) IF IMMUNIZED AGAINST.</b></p> <table style="width: 100%;"> <tr> <td>POLIO</td> <td>WHOOPING COUGH</td> </tr> <tr> <td>SMALL POX</td> <td>MEASLES</td> </tr> <tr> <td>DIPHTHERIA</td> <td>RUBELLA</td> </tr> </table> <p>Date of Last Tetanus Booster _____</p> <p>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.</p> <p><b>IMPORTANT</b> 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.</p> <p>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.</p> <p>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.</p> <p>BIG SANDY CAMP MAY USE PHOTOS, VIDEO, OR COMMENTS, OF THE CAMPER NAMED ABOVE IN ITS PROMOTIONAL MATERIALS.</p> <p>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.</p> <p>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.</p> <p>ALL ABOVE INFORMATION IS CORRECT AS LISTED.</p> <p>SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____</p>	POLIO	WHOOPING COUGH	SMALL POX	MEASLES	DIPHTHERIA	RUBELLA
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