

Extreme Faith Camp 2020
Extreme Team / Prayer Team Permission Form – Church of St Peter

PARENTAL/GUARDIAN CONSENT AND INDEMNITY AGREEMENT

Participant's Name: _____

Home Address: _____

City: _____ **State/Zip:** _____ **Home Phone:** _____

Email(s): _____

Date of Birth: ___/___/___ **Sex:** ___ Male ___ Female **Current Grade (May 2020):** ___

Parent/Guardian's Name: _____ **Ph:** _____

Adult T-Shirt Size: SM MED LG XL XXL XXXL **C:** _____

Parish: Church of St Peter

Type/Date of Event: Extreme Faith Camp 2020-Saturday, June 20-Friday, June 26

Location: Big Sandy Camp – McGregor, MN **Group Leader:** David Flynn

Travel Details: Departure: Saturday, June 20 **Return:** Friday, June 26

Mode of Transportation: Private cars up, bus back

Cost of Event: \$340 if paid in full by Feb 15; Otherwise \$400

April 17th is the FINAL DEADLINE

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

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

I give permission for Extreme Faith Camp and/or The Church of St Peter to take and release photographs and film for publication of my child/teen.

Parent/Guardian Signature: _____ **Date** _____

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 the Church of St Peter 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** _____

I give permission for EFC and/or the Church of Saint Peter to take and release photographs and film for publication of my child.

Parent/Guardian Signature: _____ **Date** _____

EMERGENCY MEDICAL TREATMENT: In the event of an emergency, I give permission to transport my child to a hospital for medical treatment. I agree to allow my child to receive emergency medical treatment at my expense at the discretion of the event sponsors. 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:

Emergency Contact Name

Relationship

Phone Number (best number)

HEALTH INFORMATION:

***A Copy of Your Medical Insurance Card **Must** be attached to this form in order for it to be processed.

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 _____

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 the Church of St Peter , 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:** _____

If your Child is taking Medications and will need to take these medication during the event: My child will bring all such medications necessary, and such medications will be in the originally marked bottles. 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: the Church of St Peter 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: _____

BIG SANDY YOUTH REGISTRATION / MEDICAL FORM

YOUTH REGISTRATION / MEDICAL FORM

camper name	M	F
address		
city	state	zip
home phone	email address	
grade	age at camp	birthdate / /
retreat / camp session	date	year
church sponsoring, if any		
parent or guardian ()	emergency contact person ()	
emergency home phone #	emergency cell phone #	
health insurance company		
insurance ID #	group #	
physician's name	phone #	

HEALTH HISTORY – CHECK (✓) THOSE THAT APPLY

<input type="checkbox"/> RECENT SURGERY	<input type="checkbox"/> CHRONIC ILLNESS
<input type="checkbox"/> FAINTING	<input type="checkbox"/> CONVULSIONS/SEIZURES
<input type="checkbox"/> HEART TROUBLE	<input type="checkbox"/> DIABETES
<input type="checkbox"/> MIGRAINES	<input type="checkbox"/> NOSEBLEEDS
<input type="checkbox"/> HEAD LICE	<input type="checkbox"/> BEDWETTING
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> NIGHTMARES
<input type="checkbox"/> MENTAL HEALTH / BEHAVIORAL	<input type="checkbox"/> SLEEPWALKING
<input type="checkbox"/> KIDNEY TROUBLE	<input type="checkbox"/> OTHER (LIST)

ALLERGIC TO: FOOD MEDICINE THE ENVIRONMENT
 EXPLAIN: _____

IMMUNIZATION RECORD – CHECK (✓) IF IMMUNIZED AGAINST.
 CHICKENPOX HEPATITIS B
 POLIO MMR
 DIPHTHERIA, PERTUSSIS, TETANUS
 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

PRESCRIPTION DRUG AND MEDICINE AUTHORIZATIONS
(USE THIS FORM ONLY IF MEDICATION IS TO BE GIVEN TO YOUR CHILD
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 _____

Reason for medication _____

I, _____, hereby authorize the Church of St Peter to dispense
Parent /Guardian Name

medicine to _____ as directed above.
Participants Name

Signature of Parent/Guardian of Participant

Date