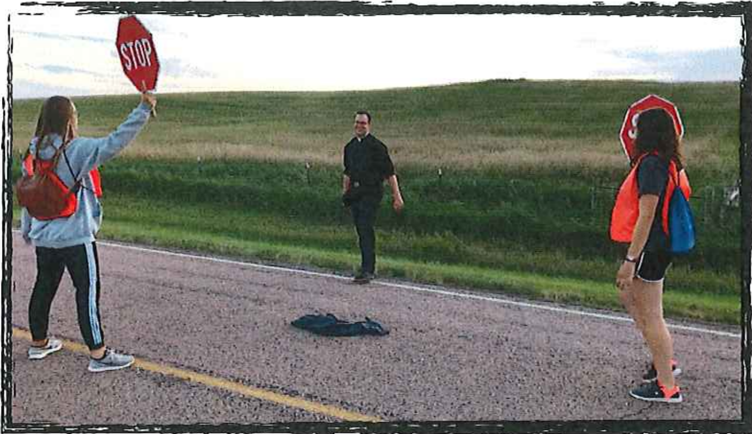
CAMP VERITAS

ALL 8TH–12TH GRADERS (THIS PAST YEAR)

SOME COLLEGE STUDENT SPOTS ALSO

SUNDAY JULY 26 – THURSDAY JULY 30



JOIN US!!

COST
$200

THEME: **THE WAY LEADS TO TRUTH**

St. Charles Camp Veritas Permission Slip

Place: Broom Tree Retreat Center, South Dakota

Participant Name: ____T-shirt size __________

Date of Birth: ___/___/___ Sex: M / F Grade in Fall (2020-21): ____ (Past 8-12 Graders Eligible)

Parent/Guardian Name:__________________________ Home Address: ___________________________

Email: ____________________________________ ___________________________

Best Phone: ______________________________Text messages ok? Y or N (please circle one)

Event: Extreme Faith Camp Date: **July 26th- July 30th**

Drop-Off On June 26th at 11:30am AND Pick up on June 28th at 2:30-3pm

Transportation will be by Parent Carpools (I know this is a lot to ask but hopefully many of the adults who drive will be our small group leaders for the week)

Cost: $200 for the whole week of camp Total amount owed due by **July 1st**

Person(s) in Charge: **<u>Andrew Wagenbach</u> and Adult Leaders from St. Charles**

I, ____________________________ (Parent or Guardian Name), grant permission for ______________________________ (Youth Name)

to participate in the above named activity 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. Charles****, all Churches participating, and the Archdiocese of St. Paul & Minneapolis* from any claims or law suits brought against the **Church of St. Charles**, *all Churches participating, and the Archdiocese of St. Paul & Minneapolis* 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. Charles****, all Churches participating, and the Archdiocese* in defense of such a claim/suit. Should photos or video be taken, I give my permission for the use of my child's image and /or likeness in any promotional or other marketing activities relating to the youth ministry programs of ***Church of St. Charles*** *and all Churches participating.*

EMERGENCY MEDICAL TREATMENT: In the event of an emergency, I give permission to transport my child to a hospital for medical treatment. 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/Relation) ____________________ (Emergency Phone Number)

<u>Camp Activities:</u> Unless indicated I give permission for my child to participate in the list of activities mentioned on the pre-registration form such as: swimming, canoeing, Fishing, paddle boating, etc. <u>Indicate here activities not to participate in if any</u>:

____

OPTIONAL MEDICAL INFORMATION:

Medication my teen is taking at present: ______________________________

Family Health Plan carrier number: ______________________________

Family Doctor: ____________________ Phone Number: __________________

As Parent or Guardian, I agree to all of the above stated considerations and conditions.

Signature: ____________________________________ Date: __________________ **<u>Over ></u>**

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, my teen is in good health, and I assume all responsibility for the health of my teen. (*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. Charles*** *or any of the other Churches participating,*, its officers, directors and agents, and the Archdiocese of Saint Paul & Minneapolis, chaperons, or representatives associated with the activity that my teen becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea I want to be called and discuss treatment and also if they need to leave camp.

Signature: ______________________________ Date: ______________

Medications: My teen is taking medication at present. My teen will bring all such medications necessary, and such medications will be well-labeled. Names of medications and concise directions for seeing that the teen 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 teen, if deemed appropriate.

Signature: ______________________________ Date: ______________

Specific Medical Information: ***Church of St. Charles*** *and all Churches participating,* 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 teen have a medically prescribed diet? ______________________

Any physical limitations? ______________________

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

Any special medical conditions?______________________

CODE OF CONDUCT

The following are a few rules that all participants are expected to follow while participating and representing ***Church of St. Charles*** *and all Churches participating,* in this event sponsored by ***Church of St. Charles,*** *all Churches participating.*

Please read and sign.

I, ______________________________, WILL:

Printed Name of Teen

- 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 timing responsibilities.
- Not have in my possession any tobacco, alcohol or any controlled illegal substance.

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

______________________________ ______________
Teen Signature Date

______________________________ ______________
Parent/Guardian Signature Date

Please return this form to the Parish Office by: July 1st plus any money owed.
Contact Andrew with any questions. 715-495-7715 OR awagenbach@stchb.org

PRESCRIPTION DRUG AND MEDICINE AUTHORIZATIONS

(USE THIS FORM ONLY IF MEDICATION IS TO BE GIVEN DURING THE EVENT)

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 a chaperon from the Church of St
Parent/Guardian

Charles to dispense medicine to ______________________________ as directed above.
Student

____ ____________________

Signature of Parent/Guardian **Date**