



SJN Choir Camp: Health History and Participant Release Form

Please print using blue or black ink.



Section I: Contact Information

Camper Name: _____ Nickname: _____
FIRST MIDDLE INITIAL LAST

Date of Birth: ____/____/____ Age: _____ Gender: Male Female

Grade (Fall 2018): _____ School: _____ T-shirt size (circle): Youth/Adult S M L XL

Home Address: _____
STREET CITY STATE ZIP

Parent/Guardian Name: _____ Relationship: _____
FIRST LAST

Parent/Guardian Phone: _____ Home Cell Work

Parent/Guardian Email: _____

Emergency Contact Name: _____ Relationship: _____
(IF WE CANNOT REACH THE PARENT/GUARDIAN) FIRST LAST

Emergency Contact Phone: _____ Home Cell Work

Please select a code word to be used by those picking your child(ren) up from camp: _____

TO ENSURE THE SAFETY OF YOUR CHILDREN, WE ASK THAT **ANY INDIVIDUAL** (INCLUDING PARENTS) PICKING YOUR CHILD UP FROM CAMP PROVIDE THIS CODE WORD TO OUR SIGN-OUT VOLUNTEER BEFORE THE CHILD IS RELEASED.

PLEASE INFORM THOSE WHO WILL BE TRANSPORTING YOUR CHILD OF THE CODE WORD YOU HAVE SELECTED.

ONLY ONE CODE WORD PER FAMILY IS NECESSARY. PLEASE SELECT THE SAME CODE WORD FOR EACH OF YOUR CHILDREN.

Please list any individuals who are **NOT AUTHORIZED** to pick your child up from camp:

Name: _____ Relationship: _____
FIRST LAST

Name: _____ Relationship: _____
FIRST LAST

Reasons (optional): _____

Section II: Insurance Information

Is the camper covered by family medical/hospital insurance? Yes No

Insurance Carrier: _____

Group #: _____ Member ID #: _____

Policy Holder's Name: _____ Relationship: _____
FIRST LAST

Camper Name: _____ DOB: ____/____/____

Section III: Health History

Please know that we value your privacy. Health history information is available only to our volunteer team and staff.

The camper has a history of the following:

1. Asthma 2. Diabetes 3. Seizures 4. Dizziness
 5. Headaches 6. Heart defect 7. Allergies 8. Recent injury

Please list the number and provide explanation for any checked items: _____

Section IV: Medications

If a parent or guardian of the camper is unable to be present to administer any necessary medication, only a SJN staff member or SJN Summer Camp First Aid volunteer may administer the medication pursuant to this authorization.

Written instructions from the child's physician must be provided, and must state the following:

1. The child's name;
2. The name of the medication;
3. The proper dosage of the medication;
4. The purpose of the medication;
5. The time of day/circumstances in which the medication is to be administered;
6. The anticipated number of days the medication must be administered; and
7. Any possible side effects of the medication.

Any medication must be brought in a container appropriately labeled by a pharmacy or the child's physician, and must be picked up with the child at the end of day. If a child has a condition that might require medication on an emergency basis (e.g. in the case of a child's allergic reaction, asthma attack, etc.), the child's parent or legal guardian must provide all necessary information and training or instruction to the staff/volunteer who might be responsible for administering such medication or carrying out such medical procedures.

Section V: Release

AS PARENT AND/OR LEGAL GUARDIAN, I REMAIN LEGALLY RESPONSIBLE FOR ANY PERSONAL ACTIONS TAKEN BY THE ABOVE-NAMED MINOR CHILD. I AGREE ON BEHALF OF MYSELF, THE ABOVE-NAMED MINOR CHILD, OUR HEIRS, SUCCESSORS, AND ASSIGNS, TO HOLD HARMLESS AND DEFEND, THE ROMAN CATHOLIC DIOCESE OF CHARLOTTE, ITS OFFICERS, DIRECTORS, EMPLOYEES, CHAPERONES, REPRESENTATIVES AND AGENTS, AND ANY OTHER PARTICIPATING ENTITY OR INSTITUTION, ITS EMPLOYEES AND AGENTS, CHAPERONES, OR REPRESENTATIVES ASSOCIATED WITH THE ACTIVITIES, FROM ANY CLAIM ARISING FROM OR IN CONNECTION WITH THE ABOVE NAMED CHILD PARTICIPATING IN THE ACTIVITIES, OR IN CONNECTION WITH ANY ILLNESS OR INJURY (INCLUDING DEATH) AND/OR COST OF MEDICAL TREATMENT IN CONNECTION THEREWITH, WITHOUT LIMITATION, AND I AGREE TO COMPENSATE THE SUPERVISING ENTITY OR INSTITUTION, ITS OFFICERS, DIRECTORS AND AGENTS, AND THE ROMAN CATHOLIC DIOCESE OF CHARLOTTE, ITS OFFICERS, DIRECTORS, EMPLOYEES, CHAPERONES, REPRESENTATIVES AND AGENTS ASSOCIATED WITH THE ACTIVITIES FOR REASONABLE ATTORNEY'S FEES AND EXPENSES WHICH THEY MAY INCUR IN ANY ACTION BROUGHT AGAINST THEM AS A RESULT OF SUCH INJURY OR DAMAGE. WITH THE EXCEPTION OF THE ABOVE, 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. I GIVE MY PERMISSION FOR THE ABOVE NAMED CHILD, IN CASE OF AN EMERGENCY, TO BE TAKEN TO A PHYSICIAN AND/OR HOSPITAL BY EITHER THE SUPERVISOR IN CHARGE OR BY AN ADULT AUTHORIZED BY THE SUPERVISOR IN CHARGE. I UNDERSTAND THAT EVERY REASONABLE EFFORT WILL BE MADE TO CONTACT ME. IF I CANNOT BE REACHED, HOWEVER, I HEREBY GIVE PERMISSION TO THE PHYSICIAN SELECTED BY SAID ADULT TO HOSPITALIZE AND SECURE PROPER TREATMENT (INCLUDING SURGERY) FOR THE ABOVE NAMED CHILD; AND FOR THE RELEASE OF MEDICAL RECORDS TO MEDICAL PERSONNEL. THE COST OF ANY MEDICAL CARE OR TREATMENT OBTAINED FOR THE BENEFIT OF THE ABOVE NAMED CHILD SHALL BE MY EXPENSE AND NOT PAID BY THE ROMAN CATHOLIC DIOCESE OF CHARLOTTE. I AUTHORIZE ST. JOHN NEUMANN CHURCH AND THE DIOCESE OF CHARLOTTE TO USE PHOTOS OR VIDEO OF MY CHILD TAKEN DURING SJN SUMMER CAMP FOR PROMOTIONAL PURPOSES.

Parent/Guardian Signature: _____ Date: _____

In-person: Payment must be submitted at the time of registration.
Online: Payment must be received within 5 days or risk forfeiture of spots. Send form to katie@4sjnc.org.

Registration Fee: \$20
Paid: ____/____/2018
Method: _____

**OFFICE
USE ONLY**