SJN Sunset Camp: Health History and Participant Release Form

Please print using blue or black ink.

Section I: Contact Information

Please supply information for each family member who will participate.

Participant Name: ____ Date of Birth: _____/_____/______
FIRST MIDDLE INITIAL LAST
Age if under 21: ________ Grade, if student (Fall 2021): ________ Note: students 5 and under will go to Child Care
Gender: □ Male □ Female

Participant Name: ____ Date of Birth: _____/_____/______
FIRST MIDDLE INITIAL LAST
Age if under 21: ________ Grade, if student (Fall 2021): ________ Note: students 5 and under will go to Child Care
Gender: □ Male □ Female

Participant Name: ____ Date of Birth: _____/_____/______
FIRST MIDDLE INITIAL LAST
Age if under 21: ________ Grade, if student (Fall 2021): ________ Note: students 5 and under will go to Child Care
Gender: □ Male □ Female

Participant Name: ____ Date of Birth: _____/_____/______
FIRST MIDDLE INITIAL LAST
Age if under 21: ________ Grade, if student (Fall 2021): ________ Note: students 5 and under will go to Child Care
Gender: □ Male □ Female

Participant Name: ____ Date of Birth: _____/_____/______
FIRST MIDDLE INITIAL LAST
Age if under 21: ________ Grade, if student (Fall 2021): ________ Note: students 5 and under will go to Child Care
Gender: □ Male □ Female

Participant Name: ____ Date of Birth: _____/_____/______
FIRST MIDDLE INITIAL LAST
Age if under 21: ________ Grade, if student (Fall 2021): ________ Note: students 5 and under will go to Child Care
Gender: □ Male □ Female

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

Section II: Insurance Information

Insurance Carrier: ____

Person(s) insured: ____
Group #: ____ Member ID #: ____

Policy Holder's Name: ____
FIRST LAST

Section II: Secondary Insurance Information

Insurance Carrier:

_____

Person(s) Insured: _____

Group #: _____ Member ID #: _____

Policy Holder's Name: _____

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
Who? _____

□ 2. Diabetes
Who?_____

□ 3. Seizures
Who?_____

□ 4. Dizziness
Who _____

□ 5. Headaches
Who _____

□ 6. Heart defect
Who _____

□ 7. Allergies
Who _____

□ 8. Recent injury
Who _____

□ 9. Other
Other _____

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

_____

Section V: Release

As parent and/or legal guardian, I remain legally responsible for any personal actions taken by myself and the above-named family members. I agree on behalf of myself, the above-named family members, 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 family members 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, all the family members participating are in good health, and I assume all responsibility for the health of my child. I give my permission for the above named family members, 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 family members; 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 family members 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 family taken during SJN Summer Camp for promotional purposes.

Section VI:

Adults and Teens: We need Volunteers! Please check the area (s) you are interested in volunteering.

☐ **Hospitality, Set up, Clean up. Are you willing to come early or stay late?** ☐ yes ☐ no

☐ **Games** ☐ Music

☐ **Crafts** ☐ Faith

***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 kelly@4sjnc.org.*

Registration Fee: $50
Paid: ____/____/2021
Method: _____

OFFICE USE ONLY