



# Totus Tuus: 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 2021): \_\_\_\_\_ School: \_\_\_\_\_

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: \_\_\_\_\_

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### 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.

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### 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: \_\_\_\_\_

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### Section VI: Program Selection and Payment

Please select the appropriate program for your child:

- \_\_\_\_ Day Program: Rising 1st graders-rising 6th graders (June 21-25, 9am-2:30pm)  
\_\_\_\_ Evening Program: Rising 7th graders-graduated 12th graders (June 20-26, 7-9pm)

*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 jose@4sjnc.org.*

Registration Fee: \$25  
Paid: \_\_\_\_/\_\_\_\_/2021  
Method: \_\_\_\_\_

**OFFICE  
USE ONLY**