

St. Joseph's Parish Youth Ministry -CHWC July 21-27, 2024

St. Joseph, Hillsborough, NJ Catholic Heart Workcamp
 Location of Activities/Events: **Niagara University, Niagara Falls, NY**
 Coordinator of Youth Ministry: **Bob Ferretti, 908-864-0064**
bobf@sjmillstone.com



Participant Information			
Name:		Email:	
Address:		Phone:	
Parent/Guardian Information:			
Name		Mobile Phone:	
		Email Address:	
Name		Mobile Phone:	
		Email Address:	
In Case of Emergency: Please provide someone other than the parent/guardians listed above.			
Name:		Phone:	
Relationship:			

Please complete the following question if your child has specific medical needs – this information will help us meet your child's needs and will not categorize your child in any way. Check all that might apply.

- | | |
|---|--|
| <p><input type="checkbox"/> Prescription Medication(s) please list:</p> <p>_____ dosage: _____</p> <p>_____ dosage: _____</p> <p>_____ dosage: _____</p> <p><input type="checkbox"/> Food Allergy: _____</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Epi-pen*: _____</p> <p>* Please note: if your child must carry an Epi-pen, permission slips must be signed by a parent and medical provider.</p> | <p><input type="checkbox"/> I give permission to administer OTC medications:</p> <p><input type="checkbox"/> Acetaminophen (Tylenol)</p> <p><input type="checkbox"/> Ibuprofen (Advil or Motrin)</p> <p><input type="checkbox"/> Cough drop (non-medicated)</p> <p><input type="checkbox"/> Topical medication (antibiotic ointment, calamine lotion, hydrocortisone cream)</p> <p><input type="checkbox"/> Antacid (Tums, Rolaids)</p> <p><input type="checkbox"/> Antihistamine oral (Benadryl, diphenhydramine, cetirizine)</p> <p><input type="checkbox"/> Eye drop (non-medicated lubricating)</p> <p><input type="checkbox"/> Antihistamine allergy eye drop</p> |
|---|--|

Additional Family Information: Please provide any additional information that you think we should be aware of.

St. Joseph's Parish Youth Ministry –CHWC July 21-27, 2024

CONSENT For Child (if under 21): I/we consent to my child, _____ (“my child”), participating in the above-described activities/program. I/we specifically waive and release any and all claims of any nature which I/we may have now or in the future against the above-named parish and/or school, the Diocese of Metuchen, their representatives, employees, agents, and assigns (including, but not limited to, staff and adult supervisors) arising out of, related to, or connected in any way with the above-described activity including, but not limited to, claims that may be derived from any accident or injury sustained by my child or damages or loss to property in route to, during, and/or returning from the activity.

CONSENT For Self (if 21 and older): I, _____ participating in the above-described activities/program. I specifically waive and release any and all claims of any nature which I may have now or in the future against the above-named parish and/or school, the Diocese of Metuchen, their representatives, employees, agents, and assigns (including, but not limited to, staff and adult supervisors) arising out of, related to, or connected in any way with the above-described activity including, but not limited to, claims that may be derived from any accident or injury sustained by me or damages or loss to property in route to, during, and/or returning from the activity.

AUTHORIZATION FOR MEDICAL TREATMENT

Should emergency medical treatment be necessary and I/we cannot be reached immediately, I/we authorize the delegated agents of the above-named parish to consent to medical or surgical treatment of an emergent or non-emergent nature, including in-patient or out-patient hospitalization, to be rendered to my child under the general or special supervision and advice of a physician, surgeon or dentist. Such consent may include, but it not limited to, medical or surgical diagnosis or treatment, diagnostic tests, blood tests, x-rays, transfusions, intravenous treatments, administration of medication or anesthetics, and any related procedures that may be deemed advisable or necessary. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power to the delegated agents of the above-named parish to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician, surgeon or dentist, in the exercise of his/her best judgment, may deem advisable. I/we understand that I/we assume all financial responsibility for the delivery of such care at the time that such care is provided by the agency, hospital, or facility. I/we further understand that Diocesan and/or parish representatives are NOT permitted to dispense medication—unless parents previously discussed a child’s need for a specific medication also noted on this form. In the event that my child requires medication during the above described activity, I/we understand that my child must be trained to self-administer medication or have a parent in attendance to administer medication.

PHOTO RELEASE

I/we hereby grant to the Diocese of Metuchen and its parishes, schools and assigns, the irrevocable and unrestricted right to use, reproduce and publish photograph(s) or video(s) of my child, including their image and likeness for diocesan, parish or school publications, advertising, or website(s), or any other purpose and in any manner and medium; to alter the same without restriction; and to copyright the same. I/we hereby release The Diocese of Metuchen and its trustees, officers, employees, agents, legal representatives, and assigns from any and all claims, actions, and liability of whatever nature and relating to the use of said photograph(s) and/or video(s).

DISCIPLINE / TRANSPORTATION OR DAMAGE COSTS

I/we agree that I/we have read and fully understand the Office of Youth & Adult Ministry’s Policies and Rules of Conduct (visit www.diometuchen.org/yyam) and I/we agree to adhere to them. I/we agree to respect the rights and property of others and further understand that vandalism, stealing or insubordination will not be tolerated. I/we assume all responsibility for any and all financial obligations that result from any such behavior or the violation of the Policies and Rules of Conduct. Should it be necessary for my child to return home due to medical reasons, disciplinary actions or otherwise, I/we assume all responsibility and transportation costs.

Participant Name (Print): _____ Date: _____

Participant Signature: _____

Parent/Legal Guardian Name (Print): _____ Date: _____

Signature of Parent/Legal Guardian: _____

(Please have parent/legal guardian sign if under 21 years old)

St. Joseph's Parish Youth Ministry -CHWC July 21-27, 2024

NYS Health Department Medical Requirements

Participant Name: _____

7-2.8 Medical requirements.

(c)(1) A current confidential medical history, including the child's immunization record which shall include immunization dates against

Immunization Against:	Dates:
Diphtheria	
Haemophilus Influenza Type B	
Hepatitis B	
Measles	
Mumps	
Poliomyelitis	
Rubella	
Tetanus And Varicella (Chicken Pox)	

shall be kept on file for every camper and updated annually. The camper's and staff's family or other responsible person's name, address and telephone to contact during an emergency shall be kept on file.