CAMP DeSales

1198 DeSales Drive •. Brooklyn MI 49230 •. 517-592-2074 •. www.desales.org

Dear Missionaries, Youth Ministers, Campus Ministers, Adult Chaperones and Volunteers,

The State of Michigan requires all adults at Camp to complete the medical history form below. The Diocese of Lansing requires *Virtus* training. This can be done online if you have not already done so. Please contact Camp if you need assistance.

Many Catholic youth camps ask parish/school adult chaperones/ministers to stay overnight in the cabins. This provides an opportunity to better know the campers and it is a big help to the program/missionaries. Cabin counselors will be asked to review our staff handbook/ safety procedures and then participate in a two hour orientation session in Toledo at a mutually agreeable time. The State of Michigan requires background checks, references and training. Those not in cabins will sleep in Lawrence Lodge.

The form below is a "fillable-pdf" which provides the option to enter the information before printing.

Thank you for your involvement this summer. Please join us in prayer for the campers and for ourselves. May the Holy Spirit lead us all to the feet of Christ, deepen our faith, clothe us in virtue, and help us experience the joys of God's Kingdom this summer at Camp.

Fr. Ken McKenna, OSFS
Camp Director
mckenna@desales.org

CAMP DeSales

Missionary, Youth/Campus Minister, Chaperone, and Volunteer Registration Form

Please print:

Name: _____ **Date of Birth:** _____ **Gender:** ____

Address: _____

Camp Session Dates:_____ **Email:** _____

Virtus training/background check complete? (documentation required, call for details): _____

Cell Phone: _____ **Other Phone:** _____

***If Applicable*: Coming with which parish or school:** _____ **T -Shirt Size:** _____

I am willing/able to stay overnight in a cabin if needed: _____

STAFF, YOUTH MINISTER AND VOLUNTEER HEALTH HISTORY AND RELEASE OF LIABILITY FORM

PERSONAL INFORMATION

LAST Name *(printed):*	FIRST Name *(printed):*	Date of Birth (Month, Day, Year):
Home Address:		Camp Arrival Date:
		Camp Departure Date:

EMERGENCY CONTACT INFORMATION

Name	Relationship	Cell Phone Number	Alternate Phone Number
Alternate Contact (optional)	Relationship	Cell Phone Number	Alternate Phone Number
Alternate Contact (optional)	Relationship	Cell Phone Number	Alternate Phone Number
Alternate Contact (optional)	Relationship	Cell Phone Number	Alternate Phone Number

INSURANCE INFORMATION

Camp DeSales does not carry health/accident insurance for staff volunteers and missionaries. In the case that you need advanced medical care, please complete the section below and bring a copy of your insurance card to camp.

Primary Policy Holder	Relationship to Camper	Insurance Company	Policy Number
Physician's Name	Physician's Phone Number	Date of Last Doctor's Visit	

RELEASE OF LIABILITY

I freely choose to participate in the mission and work of Camp DeSales and all related activities, including any activities incidental to such participation (hence called "Volunteer Activities"), I, the undersigned Volunteer, releases and agrees not to sue Camp DeSales, d/b/a of Lake Vineyard Camps, Inc. or its officers, directors, employees, sub-contractors, sponsors, agents or the Oblate Fathers of St. Francis de Sales, Inc., (hence called the "Camp") from all present and future claims that may be made by me, my family, estate, heirs, or assigns for property damage, personal injury, or wrongful death arising as a result of my participation in the Volunteer Activities wherever, whenever, or however the same may occur.

I understand and agree that the Camp is not responsible for any injury or property damage arising out of the Volunteer Activities, even if caused by their ordinary negligence or otherwise.

I understand that participation in the Volunteer Activities involves certain risks, including, but not limited to, serious injury and death. I am voluntarily participating in the Volunteer Activities with knowledge of the danger involved and I agree to accept all risks of participation.

I also agree to indemnify and hold harmless the Camp for all claims arising out of my participation in the Volunteer Activities.

I understand that this document is intended to be as broad and inclusive as permitted by the laws of the State of Michigan where the Volunteer Activities take place and agree that if any portion of this Agreement is invalid, the remainder will continue in full legal force and effect.

I also acknowledge that the Camp has not arranged and does not carry any insurance of any kind for my benefit or that of my parents, guardians, trustees, heirs, executors, administrators, successors and assigns. I represent that, to my knowledge, I am in good health and suffer no physical impairment that would or should prevent my participation in Volunteer Activities.

I also understand that this document is a contract which grants certain rights to and eliminates the liability of the Camp. I am of legal age and am freely signing this agreement. I have read this form and understand that by signing this form, I am giving up legal rights and remedies.

Signature:_____ Date: _____

If adult volunteer is under parent/guardians' insurance: I, the above volunteer's parent or legal guardian, have read the Release of Liability Form above and understand that my adult child, who is covered under my insurance policy, has signed it.

Parent/Guardian Signature:_____ Date: _____

Name: ______________________________ Arrival Date: ______________

MEDICATIONS

Camp DeSales stocks the following over-the-counter medications to manage illness and injury as directed by our medical protocols. Staff will have access to Aloe Gel, Antacid, Antibiotic Ointment, Anti-diarrheal (loperamide), Benadryl, Burn Gel (lidocaine), Cough Drops, Cough Syrup, Eye Wash, Gold Bond Powder, Hydrocortisone Cream, Ibuprofen, Stool Softener, Sudafed, or Tylenol to camp. Please list any medications that you should **NOT** be given:

MEDICATION INFORMATION

"Medication" is ANY substance used to maintain and/or improve an individual's health, including vitamins and supplements.

Per Michigan state law, medications must meet the following standards:

Medication must arrive in its original packaging. Medication will only be administered in age-appropriate doses according to the medication label or a signed physician's note. Medication cannot be expired, per the expiration date on the medication container.

Staff members should carry their emergency medications (epinephrine injectors, rescue inhalers and diabetic supplies) on their person while at camp. If you are sleeping in a camper cabin, your medications, vitamins and supplements must be stored at the Health Office. If assigned to a staff-only residence, medicine should be kept in your bedroom and do not have to be listed below.

All staff sleeping/supervising campers in residential cabins: *please list all medications you will bring to camp:*

MEDICATION NAME AND STRENGTH	REASON FOR TAKING	MEDICATION DOSE	WHEN GIVEN	YEAR STARTED
			☐ Breakfast ☐ Bedtime ☐ Lunch ☐ As Needed ☐ Dinner ☐ Other: __________	
			☐ Breakfast ☐ Bedtime ☐ Lunch ☐ As Needed ☐ Dinner ☐ Other: __________	
			☐ Breakfast ☐ Bedtime ☐ Lunch ☐ As Needed ☐ Dinner ☐ Other: __________	
			☐ Breakfast ☐ Bedtime ☐ Lunch ☐ As Needed ☐ Dinner ☐ Other: __________	
			☐ Breakfast ☐ Bedtime ☐ Lunch ☐ As Needed ☐ Dinner ☐ Other: __________	

NUTRITION

☐ I have **no** dietary restrictions

I have the following dietary restrictions:

☐ No beef ☐ Gluten-intolerant
☐ No pork ☐ Lactose-intolerant
☐ Vegetarian (no meats/seafood) ☐ Vegan (no meats/seafood/eggs/dairy)

Please provide additional dietary information, if necessary:

Camp DeSales prepares well-balanced meals. We work with dietary concerns but do not cater to individual food preferences. Please email mckenna@desales.org if you have questions pertaining to your dietary needs.

Name: _____ Arrival Date: _____

ALLERGIES

I have: ☐ No Known Allergies ☐ Seasonal Allergies ☐ Food Allergies ☐ Medication Allergies ☐ Other Allergies

Please list what you are allergic to, your reaction and how it is treated:

Do any of the above cause an anaphylactic (life-threatening) reaction?

☐ No ☐ Yes If ingested ☐ Yes if touched ☐ Yes if airborne

HEALTH HISTORY

Please check any of the following that pertain to you:

☐ Asthma	☐ Diarrhea and/or Constipation	☐ Menstruation Issues	☐ Vision Concern
☐ Diabetes	☐ Eating Disorder	☐ Migraines	☐ Recent Illness and/or Injury
☐ ADD/ADHD	☐ Fainting	☐ Mobility Concern	☐ Recent Surgery
☐ Autism	☐ Hearing Impairment	☐ Seizure Disorder	☐ Recent Hospitalization
☐ Bedwetting	☐ Head Injury	☐ Sleepwalking	☐ Last Tetanus Shot _____
☐ Bleeding Disorder	☐ Heart Condition	☐ Skin Issues	☐ Other _____
☐ Chronic Pain/Injury	☐ Homesickness	☐ Traveled Outside USA	
☐ Chronic Pain/Injury	☐ Mental Health Concern	within the last year	☐ None of the Above

Please give details about checked items and note any activity restrictions due to your health history. If you would like to discuss a special concern, contact Camp DeSales at 517-414-0784.