CAMP DESALES HEALTH, GENERAL RELEASE OF LIABILITY AND AUTHORIZATION FOR TREATMENT FORM

PERSONAL INFORMATION

Camper's LAST Name *(printed):*	Camper's FIRST Name *(printed):*		Date of Birth (Month, Day, Year):
Home Address:	Height:	Weight:	Camp Arrival Date:
	Gender:	Age:	Camp Departure Date:

EMERGENCY CONTACT INFORMATION

Parent/Guardian *(Primary Contact)*	Relationship to Camper	Cell Phone Number	Alternate Phone Number
Parent/Guardian *(Secondary Contact)*	Relationship to Camper	Cell Phone Number	Alternate Phone Number
Alternate Contact Name	Relationship to Camper	Cell Phone Number	Alternate Phone Number
Alternate Contact Name	Relationship to Camper	Cell Phone Number	Alternate Phone Number

INSURANCE INFORMATION

Camp DeSales does not carry health/accident insurance for campers, schools or parish camping groups. In the case that your child needs advanced medical care, **please attach a copy of your insurance card, front and back sides, to this form.**

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

PARENT/GUARDIAN AUTHORIZATION

The information contained in this form is correct, as far as I know, and the child herein described has permission to engage in all camp activities, including, but not limited to, waterfront activities, boating, tubing, paintball, and low-ropes course, except as noted on page. 4. I understand that health/accident insurance coverage is the responsibility of the parent/guardian. I hereby give permission to Camp DeSales to secure emergency medical, routine medical, surgical treatment, and non-surgical care for the child named on this form, while at camp. I also understand that the parent/guardian is fully responsible for the camper's transportation if he/she is dismissed for disciplinary, behavior or medical reasons. I absolve Camp DeSales, Lake Vineyard Camps, Inc. and the Oblate Fathers of St. Francis de Sales and all of its officers, employees of any and all liability, financial and/or otherwise arising from administration of medication to my child under the terms of this release. Camp DeSales is not responsible for payment of any medical expenses incurred during participation at camp.

In consideration for being allowed to participate in programs at Camp DeSales, I agree to assume the risk of such activities and programs, and I further agree to hold harmless Camp DeSales, Lake Vineyard Camps, Inc. and the Oblate Fathers of St. Francis de Sales, its officers, employees and representatives from any and all claims, suits, losses, or related causes of action for damages, including, but not limited to, such claims that may result from COVID-19, injury, or death, accident or otherwise, during or arising in any way from the activities. I grant permission for me or my child to participate in all planned camp activities. Camp DeSales is not responsible for lost, stolen or damaged personal articles. I also authorize Camp DeSales to have and use photographs, slides or video of me, my child, or my family as may be needed for its public relations programs. I acknowledge that this General Release of Liability and Authorization for Treatment is binding on me personally and on my heirs, personal representatives, successors and assigns.

Limited Purpose Power of Attorney: Consent to Treatment of Minor (Must be signed by parents or legal guardians)

By signature(s) below, the undersigned appoints Camp DeSales to act alone, or delegate to another person, the power to consent on our behalf to all emergency treatment and/or medical care (except elective surgery) of (child's name) _____ determined to be necessary or desirable by our child's attending physician at the hospital. This Power of Attorney shall continue through the participant's stay at camp, or until revoked by the undersigned, whichever is earlier. Physicians or the hospital's medical staff may assume and rely on this authorization being current and in effect during such period unless notified otherwise. The undersigned certify that they read this Power of Attorney (or had it read to them), that they understand this Power of Attorney, and sign it voluntarily. This agreement will be enforced in accordance with the law of the State of Michigan.

Parent/Guardian Signature:_____ **Date:** _____

Camper's Name: _____ Arrival Date: _____

MEDICATION PERMISSION

Camp DeSales stocks the following over-the-counter medications to manage illness and injury as directed by our medical protocols. Campers do not need to bring their personal 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 your child 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.

Please note: Campers are expected to carry their emergency medications (epinephrine injectors, rescue inhalers and diabetic supplies) on their person, while at camp. All other medications, vitamins and supplements must be stored at our Health Center.

Please list all medications your child 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: _____	

If your child takes additional medication, please list the medication, dosage and time given and attach to this health form.

IMMUNIZATIONS

Immunization	MMR (measles, mups, rubella)	DTap (diphtheria, tetanus, pertussis)	IPV (polio)
Date: Month(s) and Year(s):			

Camper's Name: _____ Arrival Date: _____

NUTRITION

☐ My child has no dietary restrictions

My child has the following dietary restrictions:

☐ No beef
☐ No pork
☐ Vegetarian (no meats/seafood)
☐ Gluten-intolerant
☐ Lactose-intolerant
☐ 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 camper's dietary needs.

ALLERGIES

My child has: ☐ No Known Allergies ☐ Seasonal Allergies ☐ Food Allergies ☐ Medication Allergies ☐ Other Allergies

Please list what your camper is allergic to, their 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 ✳

✳ If yes, please complete the additional Anaphylaxis Form.

HEALTH HISTORY

✳ If your child has Asthma and/or Diabetes, please complete the additional Asthma and/or Diabetes Form(s)

Please check any of the following that pertain to your camper:

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

Please give details about checked items and note on page 4 if your child has any activity restrictions due to their health history. If you would like to discuss a special concern with our Summer Programs Director, please call 517-414-0784.

Camper's Name: _____ Arrival Date: _____

CAMPER INFORMATION

We at Camp DeSales want your child to have the best experience possible. To help with this effort, please give any information you would like us to share with your child's camp counselors/missionaries, *including any restricted activities*.

About my camper:

What techniques are most successful for your child in the case of behavior management and/or conflict?

Does your child:				**Additional Details:**
Adjust well to change	☐ Yes	☐ Sometimes	☐ No	
Socialize easily with their peers	☐ Yes	☐ Sometimes	☐ No	
Become easily frustrated	☐ Yes	☐ Sometimes	☐ No	
Take direction well	☐ Yes	☐ Sometimes	☐ No	
Have a positive mental outlook	☐ Yes	☐ Sometimes	☐ No	

MEDICAL CONCERNS

Your child's Medical History is confidential and only shared on a need-to-know basis. Please provide any tips and/or details that you would like shared with your child's camp counselors.

Tips and/or Details:

☐ History of Bedwetting

☐ History of Sleepwalking

☐ History of Night Terrors

☐ History of Seizures

☐ Diabetic/Hypoglycemic

☐ Allergies

- ☐ Has epinephrine injector (EpiPen, Auvi-Q, etc.)

☐ Asthma

- ☐ Has rescue inhaler (Albuterol, Pro Air, Ventolin, etc.)

☐ Other: