Dear Parents,

Please complete the following forms and return them to your youth/campus minister to register your child for camp. Fill out the Anaphylaxis, Asthma, and/or Diabetes forms only if they apply to your child.

All three sessions begin Wednesday with drop off a Camp between 11 AM and Noon. Campers will be served lunch. Sessions conclude Sunday with Noon Mass for all campers and families, followed by a picnic. Camp DeSales will provide brats, hot dogs, lemonade and potato chips. Feel free to bring drinks, a side dish and/or dessert to share.

Packing lists and other information are available on our website (desales.org). If you have any questions, please contact me or your parish or school youth minister.

We are looking forward to another wonderful summer. Thank you for your participation and prayers.

Fr. Ken McKenna, OSFS
Camp Director

CAMP DeSales

Catholic Youth Camp Registration Form 2023

Please print:

Camper's Name: _____

Address: _____

Attending with (name of Catholic parish or school): _____

Session: ☐ **Session 1** (July 5-9) ☐ **Session 2** (July 12-16) ☐ **Session 3** (July 26-30)

Camper's Upcoming Grade Level: _____ **T -Shirt Size:** _____ (Adult sizes) **Denomination:** ☐ **Catholic** ☐ **Other**

If your child cantors, lectors, or serves at Church, pls. indicate: _____

Name of Mother/Legal Guardian #1: _____

Mother/Legal Guardian #1: Cell Phone _____ **Email:** _____

Name of Father/Legal Guardian #2 _____

Father/Legal Guardian #2: Cell Phone _____ **Email:** _____

Other phone numbers (e.g. work/home): _____

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

Please note: If your child has Covid or flu symptoms before camp begins, please contact Camp for the latest requirements of the Michigan Health Department. Campers who cannot attend camp due to illness will receive a full refund.

Starred (✳) immunizations MUST be current. **Please attach a copy of your child's immunization records to this form.**

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 below.

HEALTH HISTORY

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

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.

☐ 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:

CAMP DeSales

Camper Release Consent Form

Michigan Youth Camp Safety Laws require licensed camps to get authorization from parent/guardians for the release of their child to specific individuals. Please indicate below the individuals to whom your son or daughter may be released and make sure they bring a photo ID when they come to Camp.

Persons authorized to pick up your child must be listed below with name and contact information regardless of their relationship to the child. For example, if you, the parent will be picking up your child, please list your name immediately below. Also, list additional relatives, friends, etc... who might be picking up your child in your absence.

You may make changes to this form at any time prior to pick up. **All** changes must be made in writing by the parents/guardians and submitted to the camp office.

Please Print:

Camper's Name: _____ **Program Dates:** _____

(1) **Name of person authorized to pick up your child:** _____

Their relationship to camper: _____ **Their cell phone:** _____

Their work or home phone: _____ **Their signature (if available):** _____

(2) **Alternate person authorized to pick up your child:** _____

Their relationship to camper: _____ **Their cell phone:** _____

Their work or home phone: _____ **Their signature (if available):** _____

(3) **Alternate person authorized to pick up your child:** _____

Their relationship to camper: _____ **Their cell phone:** _____

Their work or home phone: _____ **Their signature (if available):** _____

If parent(s) or guardian(s) are NOT listed above, please complete the information below:

Your Name: _____ *Check one:* ☐ **Mother** ☐ **Father** ☐ **Guardian**

Cell phone: _____ **Alt. phone:** _____ **Signature:** _____

Your Name: _____ *Check one:* ☐ **Mother** ☐ **Father** ☐ **Guardian**

Cell phone: _____ **Alt. phone:** _____ **Signature:** _____

To be completed ***when the camper is picked up at camp (photo ID required):***

_____	_____	_____
Signature of person picking up camper	*Date of Check-out*	*Time of Check-out*

CHILD'S NAME:_____ CAMP SESSION/DATES: _____

CAMP DESALES: ANAPHYLAXIS FORM

Complete form only of your child suffers from Anaphylactic shock.

We want your child to receive appropriate care and support for their allergies while attending our program. Please contact Fr. Ken McKenna with any questions or concerns (517-592-2074.

ANAPHYLAXIS EXPECTATIONS

CAMP DESALES programs take place in the outdoors. Your child will be exposed to trees, insects and other environmental factors. Participants are notified of food allergies at the beginning of every meal. The closest hospital, Henry Ford Allegiance Hospital in Jackson, MI, is approximately 30 minutes away.

It is our expectation that your child is capable of self-managing their allergies: knowing which allergens to avoid, recognizing when they are experiencing an anaphylactic reaction and knowing to tell an adult immediately for help. We expect your child to know how and when to use their emergency epinephrine injector and that they will carry at least one device on their person, while at camp.

ALLERGENS

Please list what allergens cause an anaphylactic reaction in your child.

ANAPHYLAXIS SIGNS AND SYMPTOMS

Please check which signs and symptoms apply to your child's anaphylaxis response. It is assumed that the severity of these signs and symptoms can change quickly and potentially progress to a life-threatening situation.	
☐ Itching of the lips, tongue, mouth and/or face	☐ Hives, an itchy rash
☐ Swelling of the lips, tongue, mouth and/or face	☐ Nausea, abdominal cramping, vomiting and/or diarrhea
☐ Itching and/or tightness in the throat	☐ Shortness of breath
☐ Hoarseness	☐ Thread-y pulse and/or increased heart rate
☐ Hacking cough, repetitive cough and/or wheezing	☐ Fainting and/or loss of consciousness

ANAPHYLASIS HISTORY

Does your child also have asthma? ☐ Yes * ☐ No * If yes, please fill out the Asthma Form
Has your child ever self-administered the emergency epinephrine injector? ☐ Yes ☐ No* ☐ My child does not have an epinephrine injector. *Our Health Officer is trained to assist in the administration of an emergency epinephrine injector if needed.
When did your child last experience an anaphylactic reaction? Please describe what happened and what treatment they received.

ALLERGY MEDICATION

Please list all routine and emergency allergy medications your child will bring to camp in the MEDICATION INFORMATION section of your child's health from. Send all medication in its original prescription container and label with your child's full name.

COMMUNICATION AND TREATMENT PROTOCOL

If exposure is suspected, but no signs or symptoms of anaphylaxis are present:	● Remove individual from allergen if possible. ● Monitor individual and take no further action unless signs/symptoms appear.
If exposure is suspected and signs or symptoms of anaphylaxis are present:	● Remove individual from allergen if possible. ● Assuming a patient airway, give 50mg (20mL) liquid diphenhydramine by mouth ● Administer 0.3cc epinephrine; repeat dose as needed ● Contact EMS and inform them it is an anaphlaxis situation
To follow a different protocol, have your physician wrtie the protocol and sign below. Attach additional information as needed. **Physician Signature:**_____ **Date:**_____	
Please provide any other information you would like us to know about your child's allergic reactions. Attach additional information as needed.	

Parent/Guardian Name	Relationship to Child	Phone Number

Parent/Guardian Signature_____ **Date:**_____

CHILD'S NAME:_____ CAMP DATE_____

CAMP DESALES: ASTHMA FORM

Complete form only of your child suffers from Asthma.

We want your child to receive appropriate care and support for their allergies while attending our program. Please contact Fr. Ken McKenna, OSFS, with any questions or concerns (517-414-0784).

ASTHMA EXPECTATIONS

CAMP DESALES programs take place in the outdoors. Your child will be exposed to trees, grass, dust, pollens, molds, insects, and other environmental factors. The closest hospital, Henry Ford Allegiance Hospital in Jackson, MI, is approx. 30 minutes away.

It is our expectation that your child is capable of self-managing their asthma: knowing when to amend their activity level, when to use their rescue inhaler and when to seek help. We expect your child to carry their as needed rescue inhaler (Ventolin, Albuterol, Pro Air, etc.) on their person, while at camp. All other asthma medications will be stored and administered at our Health Office.

ASTHMA TRIGGERS

Please list what triggers your child's asthma. Any details would be helpful for our staff to know are appreciated.

ASTHMA MEDICATIONS

Please list all routine and emergency asthma medications your child will bring to camp in the MEDICATION INFORMATION section of your child's health form. Send all medication in its original prescription container and label with your child's full name.

PEAK FLOW METER

Does your child have a peak flow meter? ☐ Yes * ☐ No * If yes, please give details below.	
When does hour child take peak flow readings? ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other	
Green Range (personal best):	Treatment/Action Plan for Yellow and Red Ranges:
Yellow Range (cautionary):	
Red Range (dangerous):	

NEBULIZER

Does your child have a nebulizer? ☐ Yes *, routinely ☐ Yes*, only if needed ☐ No
*If yes, we have nebulizer machines located at our Health Office. Please send your child's medication and nebulizer tubing, we expect your child to know when they are in need of a nebulizer treatment.

COMMUNICATION AND TREATMENT PROTOCOL

For early asthma distress:	Child will self-administer their personal inhaler. If unavailable, staff will administer 1-2 puff's of camp's albuterol inhaler.
For acute asthma attack:	Administer child's medication, personal inhaler and/or nebulizer. If unavailable, staff will administer 1-2 puff's of camp's albuterol inhaler and/or 1-2 vials albuterol sulfate via camp's nebulizer. If they do not improve with treatment, contact EMS and parent/guardians.
To follow a different protocol, have your physician wrtie the protocol and sign below. Attach additional information as needed. **Physician Signature:**_____ **Date:**_____	
Please provide any other information you would like us to know about your child's asthma care. Attach additional information as needed.	

Parent/Guardian Name	Relationship to Child	Phone Number

Parent/Guardian Signature_____ **Date:**_____

CHILD'S NAME:_____ CAMP DATE_____

CAMP DESALES: DIABETES FORM

Complete form only of your child suffers from diabetes.

Your child will be responsible for managing their diabetes while at camp. Health Office staff will provide support including menu carb counts. Please note that we do not have diabetes educators or specialists on staff. Call 517-414-0784 for any questions.

DIABETES EXPECTATIONS

CAMP DESALES programs take place in the outdoors and your child will be more physically active than they are at home. The closest hospital, Henry Ford Allegiance Hospital in Jackson, MI, is approximately 30 minutes away.

It is our expectation that your child is capable of self-managing their diabetes: comfortable with counting carbs, recognizing if they are high or low, injecting insulin, etc. Children with insulin pumps are expected to be familiar with their pump and be able to manage pump malfunctions, changing sites and replacing turbing. Your child will carry their supplies and snacks with them while at camp. Extra supplies and snacks can be stored at our Health Office.

DIABETES INFORMATION

When does your child check their blood sugar levels?
What is your child's typical range for blood sugar readings?
When does your child inject insulin? Please include what type of insulin is used and how many units.
How often does your child have a HIGH blood sugar reaction?
Please list what signs or symptoms your child presents with when their blood sugar is **HIGH** as well as how it is managed.
How often does your child have a LOW blood sugar reaction?
Please list what signs or symptoms your child presents with when their blood sugar is **LOW** as well as how it is managed.
Has your child ever had a severe low blood sugar reaction (seizures, loss of consciousness, etc.)? ☐ Yes * ☐ No *If yes, please give details.

DIABETES MEDICATIONS

Please list all routine and emergency diabetes medications your child will be bringing to camp in the MEDICATION INFORMATION section of your child's health form. A refrigerator and sharps container are available at our Health Office.

COMMUNICATION AND TREATMENT PROTOCOL

At what point should we notify you (parent/guardian) about your child's blood sugar level?
At what point should your child be taken to a physician or hospital?
Please give any other information you would like our staff to know about your child's diabetes management plan. Attach additional infromation as needed.

Parent/Guardian Name	Relationship to Child	Phone Number

Parent/Guardian Signature_____ **Date:**_____