CAMP DeSales

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

The State of Michigan requires all parish and school campus ministers, chaperones, volunteers and camp staff and missionaries to complete the medical history form below. The State also requires background checks and the Diocese of Lansing requires *Virtus* training. Both of these can be done online if you have not already done so. Please contact me if you need assistance.

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

Joe Kochendoerfer, n/OSFS
Office Manager
kochendoerfer@desales.org

CAMP DeSales

Youth Minister, Chaperone, Volunteer, Staff and Missionary
Health History and Release from Liability Form

Please print:

Name: _____ T -Shirt Size: _____

Address: _____

Camp Session Dates:_____ Email: _____

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

Cell Phone: _____ Other Phone: _____

If you are a Youth Minister or Chaperone:

Coming with which parish or school: _____

Position at parish or school: _____

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, chaperones 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		Insurance Company	Policy Number
Physician's Name	Physician's Phone Number		

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, adult, 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.

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.

COVID-19 VACCINATION

Note: COVID vaccination completed two weeks before arrival is highly recommended but not required. Michigan State may require unvaccinated staff and volunteers to quarantine if exposed, wear masks more often and/or social distance while with campers.

Please check all that apply:

☐ I tested positive for COVID on _____ ☐ I will not be vaccinated before Camp begins.

☐ I will be vaccinated before Camp (please send dates when completed) ☐ I am vaccinated. Details below:

COVID Vaccine: ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson's Date(s) received: _____