



# St. Charles Bible Camp -- Staff Registration June 18-22, 2018

Please return this form to Faith Formation by June 1st.

If you have any questions, contact us at (937) 434-9272.

Name: \_\_\_\_\_  
(Last, First)  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Email: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
If still in school, your Grade in September: \_\_\_\_\_

**Please check one of the following:**  
 Under 18 y/o, or 18 y/o Graduating Senior - a parent needs to complete permission form on the back  
 18 y/o and Over – Must complete Virtus Certification.  
Are you Virtus trained? Yes  No   
If NO, please contact us ASAP regarding Virtus training before Camp.

### Emergency Contact and Medical Information:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

In case of an emergency, we will contact the person listed above. If you are 18 y/o and under, a parent is required to complete the permission form on the back, which provides space for an additional emergency contact. For adult staff, feel free to use the Medical Information section on the back to list any allergies, medical/special needs we should be aware of concerning your health.

### Job Preference: Indicate your job preferences and we will do our best to give you your first choice

Teacher (Adult or late teen only) - Grade preference: \_\_\_\_\_  
 Classroom Helper – Grade preference: \_\_\_\_\_  
 Group Guide - Grade preference: \_\_\_\_\_  
 Arts & Crafts  
 P.E.  
 Babysitting  
 Music

Do you wish to be with a Camper? Yes  No   
Name of Camper: \_\_\_\_\_

Are you ordering an optional Staff T-shirt? The cost is \$10.00 Yes  No   
If yes, please circle your size: AS, AM, AL, AXL, AXXL, other \_\_\_\_\_  
**Checks made payable to: St. Charles**  
For office use only: Cash: \$ \_\_\_\_\_ Check: # \_\_\_\_\_ Date: \_\_\_\_\_

Church Agency: St. Charles Borromeo  
Meeting Place: St. Charles Borromeo School  
Location: 4600 Ackerman Blvd Kettering OH 45429  
Starting/Ending Date: June 18-22, 2018  
Starting/Ending Time: 9:00 a.m.-12:00 p.m.

Activity: Bible Camp Program  
Group Leaders: Tim Clarke, Erin Fanning  
Telephone: (937) 434-9272 (St. Charles FF Office)  
Emergency No: (937) 673-5912 Tim Clarke's Cell

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**ARCHDIOCESE OF CINCINNATI**  
**PERMISSION, RELEASE AND MEDICAL POWER OF ATTORNEY** (rev. 11-2016)

1. I, the parent or lawful guardian of \_\_\_\_\_ (the "child"), give permission for my child to participate in the activity described on the Activity Information form (the "Activity") and release from all liability and indemnify the Archdiocese of Cincinnati (the "Archdiocese"), the Archbishop of Cincinnati (the "Archbishop"), both individually and as trustee for the Archdiocese of Cincinnati, and all parishes and schools within the Archdiocese, and their respective officers, agents, representatives, volunteers, and employees from any and all liability, claims, judgments, cost and expenses, including attorneys' fees, arising out of any injury or illness incurred by my child while participating in or traveling to or from the Activity and further agree not to bring or prosecute or allow to be brought or prosecuted (including but not limited to prosecution through subrogation) in my name, or on behalf of my Child, any claims, lawsuits or actions against the Archbishop, the Archdiocese, and their respective officers, agents, representatives, volunteers and employees.
2. I further understand that my Child's participation in the Activity is purely voluntary and is a privilege and not a right, and that my Child, and I on behalf of my Child, agree to my Child's participation in the Activity in spite of the risks.
3. I agree to instruct my child to cooperate with the Archbishop or his agents in charge of the activity.
4. I appoint the Archbishop or his agents who are acting as leaders of the Activity as my attorney in fact to act for me in my name and my behalf, in any way that I would act if I were personally present, with respect to the following matters if any injury, illness or medical emergency occurs during the activity or related travel:
  - (i) To give any and all consents and authorizations to any physicians, dentist, hospital or other persons or institutions pertaining to any emergency medications, medical or dental treatments, diagnostic or surgical procedures or any other emergency actions as our attorney shall deem necessary or appropriate for the best interest of the Child.
  - (ii) I understand that the agents of the Archbishop will make a reasonable attempt to contact me as soon as possible in the event of a medical emergency involving my child.
5. This power of attorney shall lapse automatically upon completion of the activity and related travel.
6. I agree that the Archbishop or his agents may use a photograph, video or other likeness of my child for promotional purposes, website and office functions and use social media and technology to communicate to my child regarding ministry related activities.
7. This acknowledgement and release is intended to be as broad and inclusive as permitted by the law of the State of Ohio, and if any portion hereof is declared invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect. This acknowledgement and release shall be construed in accordance with the laws of the State of Ohio, except for the choice of law provisions thereof. I have carefully read and understand and accept the terms and conditions stated herein and acknowledge that this Permission, Release and Medical Power of Attorney shall be effective and binding upon me, my Child, and my own and my Child's personal representative or estate, assigns, heirs, and next of kin and that I have signed this agreement of my own free will.

I have carefully read this statement, and my signature acknowledges that I fully understand the content and meaning.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Place of Employment \_\_\_\_\_ Phone: (c) \_\_\_\_\_ (h/w) \_\_\_\_\_  
Work Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone: (c) \_\_\_\_\_ (h/w) \_\_\_\_\_

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**MEDICAL INFORMATION – COMPLETED BY PARENT OR GUARDIAN – PLEASE PRINT**

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Child's Social Security # \* \_\_\_\_\_  
Allergies \_\_\_\_\_  
Medications \_\_\_\_\_  
Chronic Conditions (e.g. epilepsy, diabetes) \_\_\_\_\_  
Medical Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_  
Member's Name \_\_\_\_\_ Phone: (h) \_\_\_\_\_ (w) \_\_\_\_\_  
Member's Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Member's Social Security # \* \_\_\_\_\_  
Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

\* Social Security number is optional; however, please note that some hospitals WILL NOT treat without it.