# St. Charles Bible Camp -- Staff Registration
# June 24-28, 2019

**Please return this form to Faith Formation by June 7th.**
Feel free to contact us at (937) 434-9272.

**Please Print**

Name: ______________________________________________ Grade in September (if a student): ________
(Last, First)

**Please check one of the following:**

____ 18 y/o Graduating Senior and Younger - **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 you answered NO, please contact us ASAP regarding Virtus training before Camp.**

Email: ________________________________________________________________________________

Address: ______________________________________________________________________________
(Street, City, Zip)

Home Phone: ______________________________ Cell Phone: ____________________________________

**IN CASE OF EMERGENCY, PLEASE CONTACT:**
Name: __________________________________________ Relationship: _____________________________

Phone Number (s): ______________________________________________________________________

**If you are 18 y/o and under, a parent is required to complete and sign the Archdiocese Permission form on the back of this registration. For adult staff, feel free to complete 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 by marking your 1st choice, 2nd choice, etc.

______ Teacher - Grade preference: __________

______ Classroom Helper – Grade preference:__________

______ Group Guide - Grade preference: __________

______ Arts & Crafts

______ P.E.

______ Babysitting

______ Music

If you wish to be with a Camper, please provide their Name:

______________________________

Staff members have the option to purchase a T-shirt for $10.00.
**Checks made payable to: St. Charles**
Please circle your size: AS, AM, AL, AXL, AXXL,
Other ________________

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 21 & June 24-28, 2019
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

Name __________________________________________________________________ Birth Date_____/_____/_____

Allergies and/or Medications ________________________________________________________________________________________________________

Chronic Conditions (e.g. epilepsy, diabetes) ______________________________________________________________________________________

Medical Insurance Co. ______________________________________________________________________ Policy # ____________________________________

Member's Name _______________________________________________________ Phone: (h) _______________________ (w) ______________________

Member's Birth Date ______/______/______ Family Doctor ____________________________________________ Phone __________________________