



# Camp Veritas

BROOM TREE RETREAT CENTER-  
IRENE, SD

JULY  
25-29

Join us for 5 days of fellowship, fun, prayer, and adventure! All current 8-12 graders welcome! Contact Andrew at [awagenbach@stchb.org](mailto:awagenbach@stchb.org) or 715-495-7715 for registration!



**St. Charles Camp Veritas Permission Slip**  
Place: Broom Tree Retreat Center, South Dakota

Participant Name: \_\_\_\_\_ T-shirt size \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Sex: M / F Grade in Fall (2020-21): \_\_\_\_ Current 8-12th Eligible

Parent/Guardian Name: \_\_\_\_\_ Home Address: \_\_\_\_\_

Email: \_\_\_\_\_

Best Phone: \_\_\_\_\_ Text messages ok? Y or N (please circle one)

Event: *Camp Veritas* Date: *July 21-July 25th*

**Drop-Off On**, *July 25-noon* **AND Pick up on** / *July 29 9pm*

Transportation will be *coachbus*

Cost: \$200 for the whole week of camp

Total amount owed due by **July 1st**

Person(s) in Charge: **Andrew Wagenbach and Adult Leaders from St. Charles**

I, \_\_\_\_\_, grant permission for \_\_\_\_\_  
Parent or Guardian Name Youth Name

to participate in the above named activity and I warrant that my child is in good health. In consideration of my child's participation, I agree to indemnify the *Church of St. Charles, all Churches participating, and the Archdiocese of St. Paul & Minneapolis* from any claims or law suits brought against the *Church of St. Charles, all Churches participating, and the Archdiocese of St. Paul & Minneapolis* by myself, my child or others, that arises out of any behavior by my child at the event/activity described above. I also agree to pay reasonable attorney's fees or expenses incurred by the *Church of St. Charles, all Churches participating, and the Archdiocese* in defense of such a claim/suit. Should photos or video be taken, I give my permission for the use of my child's image and /or likeness in any promotional or other marketing activities relating to the youth ministry programs of *Church of St. Charles and all Churches participating*.

**EMERGENCY MEDICAL TREATMENT:** In the event of an emergency, I give permission to transport my child to a hospital for medical treatment. I wish to be advised prior to any further treatment by a doctor or hospital. In the event of any emergency, if you are unable to reach me at the above numbers, contact

\_\_\_\_\_  
Name/Relation

\_\_\_\_\_  
Emergency Phone Number

**Camp Activities:** Unless indicated I give permission for my child to participate in the list of activities mentioned on the pre-registration form such as: swimming, canoeing, Fishing, paddle boating, etc. Indicate here activities not to participate in if any:

**OPTIONAL MEDICAL INFORMATION:**

Medication my teen is taking at present: \_\_\_\_\_

Family Health Plan carrier number: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone Number: \_\_\_\_\_

As Parent or Guardian, I agree to all of the above stated considerations and conditions.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ **Over >**

**MEDICAL MATTERS:** I hereby warrant that to the best of my knowledge, my teen is in good health, and I assume all responsibility for the health of my teen. *(Of the following statements pertaining to medical matters, sign only those that are applicable.)*

**Medical Treatment:** In the event it comes to the attention of *Church of St. Charles* or any of the other Churches participating, its officers, directors and agents, and the Archdiocese of Saint Paul & Minneapolis, chaperons, or representatives associated with the activity that my teen becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea I want to be called and discuss treatment and also if they need to leave camp.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Medications:** My teen is taking medication at present. My teen will bring all such medications necessary, and such medications will be well-labeled. Names of medications and concise directions for seeing that the teen takes such medications, including dosage and frequency of dosage, are indicated on attached Prescription Drug & Medical Authorization Form.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby grant permission for **non-prescription medication** (such as non-aspirin products, i.e. acetaminophen or ibuprofen, throat lozenges, cough syrup) to be given to my teen, if deemed appropriate.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Specific Medical Information:** *Church of St. Charles* and all Churches participating, will take reasonable care to see that the following information will be held in confidence.

Allergic reactions (medications, foods, plants, insects, etc.): \_\_\_\_\_

Immunizations-Date of last tetanus/diphtheria immunization: \_\_\_\_\_

Does teen have a medically prescribed diet? \_\_\_\_\_

Any physical limitations? \_\_\_\_\_

Has teen recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc.? If so, date and disease or condition: \_\_\_\_\_

Any special medical conditions? \_\_\_\_\_

## CODE OF CONDUCT

The following are a few rules that all participants are expected to follow while participating and representing *Church of St. Charles* and all Churches participating, in this event sponsored by *Church of St. Charles*, all Churches participating.

*Please read and sign.*

I, \_\_\_\_\_, WILL:  
Printed Name of Teen

- Treat all other persons with respect and not cause any intentional harm (physically, emotionally, or spiritually) to any person in any way.
- Respect the property of others, including all program facilities and property.
- Follow all appropriate instructions of all personnel aiding in this event, including, but not limited to, chaperones, support staff, transportation personnel and administration.
- Be on time for all check-ins and timing responsibilities.
- Not have in my possession any tobacco, alcohol or any controlled illegal substance.

I agree that if any of these terms are violated, *St. Charles* can send the participant home at the participant/guardian's expense.

Teen Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

***Please return this form to the Parish Office by: July 1st plus any money owed.  
Contact Andrew with any questions. 715-495-7715 OR awagenbach@stchb.org***

**PRESCRIPTION DRUG AND MEDICINE AUTHORIZATIONS**  
**(USE THIS FORM ONLY IF MEDICATION IS TO BE GIVEN DURING THE EVENT)**

**The following information must be completed before medicine is given.**

Student Name \_\_\_\_\_ Name of Prescription/Medicine \_\_\_\_\_

Prescribing Doctor \_\_\_\_\_

Amount of Dosage \_\_\_\_\_

Times to be Given \_\_\_\_\_

Duration of Prescription \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize a chaperon from the Church of St  
Parent/Guardian

Charles to dispense medicine to \_\_\_\_\_ as directed above.  
Student

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date