



**the RIPPLE EFFECT**

# 2019 Summer WORK CAMP Week

***A Week Long Service Week - Right Here In Our Archdiocese!***

***Sunday July 14 to  
Friday July 19  
In and Around the  
Archdiocese of Newark***

***Cost is \$100.00 per participant  
due by June 2nd .***

**PRICE INCLUDES:**

- Lodging and meals at the St. JP II Youth Retreat Center
- Transportation to and from work sites
- Supplies for work sites
- Daily Mass
- Adoration and Confessions
- Music and more from Will Smith
- Morning and evening programming
- Nightly social events
- T-shirt & bag for each participant

Work Camp is our annual service immersion experience where we will join teens from our Archdiocese.

We will be experiencing various forms of service, hands on learning and more all while helping to make a difference in our Archdiocese.

**We can ONLY Take 15-18 Teens!**



For More Information or for Questions  
please see Valeria or Rich.  
Or contact us at [rich@stmtym.com](mailto:rich@stmtym.com)



# Work Camp 2019

“the Ripple Effect”

## Archdiocese of Newark Work Camp 2019 Program Photography Consent Form

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I, \_\_\_\_\_ (Parent/Guardian Name), hereby authorize the Archdiocese of Newark, 171 Clifton Avenue, Newark, New Jersey, to use \_\_\_\_\_'s (Student Name) name and likeness in photographs taken during the Archdiocese of Newark's Office of youth Ministry's Work Camp Week July 14-19th 2019, for use including, but not limited to, the Archdiocese of Newark's print, video, online and electronic promotional materials.

I hereby release and hold harmless the Archdiocese of Newark from any reasonable expectation of privacy or confidentiality associated with the images specified above.

I acknowledge that since my daughter's/son's participation with this program is voluntary, he/she will receive no financial compensation. I acknowledge and agree that publication of said photos confers no rights of ownership or royalties whatsoever.

I hereby irrevocably authorize the Archdiocese of Newark to edit, copy, exhibit, publish or distribute this photo for purposes of publicizing the organization's programs or for other related, lawful purpose. I waive the right to inspect or approve the finished product, including written or electronic copy, wherein the student's likeness appears.

I hereby release the Archdiocese of Newark, its contractors, its employees, and any third parties involved in the creation or publication of marketing materials, from liability for any claims by me or any third party in connection with participation in this program.

**Authorization:**

Student's Name: \_\_\_\_\_

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

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ *(if student is under 18 years of age)*

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Tel. # \_\_\_\_\_ E-mail: \_\_\_\_\_

# Archdiocese of Newark Office of Youth Ministry – Work Camp

## PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER

PARTICIPANT'S NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ T-shirt Size \_\_\_\_\_

Participants Email Address \_\_\_\_\_

Participants Cell Phone Number \_\_\_\_\_

PARENT/GUARDIAN'S NAME: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ EMERGENCY PHONE \_\_\_\_\_

I, (name of parent or guardian) \_\_\_\_\_, grant permission for my child (name of child)

\_\_\_\_\_ to participate in the Archdiocese of Newark Youth Ministry Work Camp to be held at the St. JP II Youth Retreat Center and in parishes throughout the Archdiocese of Newark, NJ July 14-19th, 2019( the "Program")

For value received, I agree on behalf of myself, my child's other parent if known or living (name of parent) \_\_\_\_\_

\_\_\_\_\_ my child named herein, or our heirs, successors, and assigns, to hold harmless and defend the Archdiocese of Newark, Youth and Young Adult Ministry ("OYM"), its officers, directors, and agents, and all parishes within the archdiocese, and the officers, agents, representatives, volunteers and employees of either the archdiocese or any parish thereof, and chaperones or representatives associated with the "Program" with respect to any and all actions, claims or demands that may be made or brought against OYM, its officers, directors and agents, and the Archdiocese of Newark and all parishes within the archdiocese, and the officers, agents, representatives, volunteers and employees of either the archdiocese or any parish thereof, and chaperones or representatives associated with the "Program", arising from or in connection therewith, and I agree to compensate OYM, its officers, directors and agents, and the Archdiocese of Newark and all parishes within the archdiocese, and the officers, agents, representatives, volunteers and employees of either the archdiocese or any parish thereof, and chaperones or representatives associated with the "Program" for reasonable attorney's fees and expenses arising in connection therewith.

**MEDICAL MATTERS:** I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child. Of the following statements pertaining to medical matters, **sign only those in accordance with your wishes.**

**Emergency Medical Treatment:** In the event of an emergency, I hereby give permission to OYM, its officers, directors and agents, and the Archdiocese of Newark and all parishes within the archdiocese, and the officers, agents, representatives, volunteers and employees of either the archdiocese or any parish thereof, and chaperones or representatives associated with the "Program" to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

NAME and RELATIONSHIP: \_\_\_\_\_

Telephone: \_(\_\_\_\_\_)\_\_\_\_\_

FAMILY DOCTOR: \_\_\_\_\_

Telephone: \_(\_\_\_\_\_)\_\_\_\_\_

FAMILY HEALTH PLAN CARRIER: \_\_\_\_\_

Policy Number: \_\_\_\_\_

(1) Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE TURN OVER AND COMPLETE BACK OF THIS FORM**

**Other Medical Treatment:** In the event it comes to the attention of OYM, its officers, directors and agents, and the Archdiocese of Newark and all parishes within the archdiocese, and the officers, agents, representatives, volunteers and employees of either the archdiocese or any parish thereof, and chaperones or representatives associated with the "Program", that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called REGARDLESS of the Time, etc.

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

**Medications:** My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well-labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage are as follows:

**(3) Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

No medication of any type whether prescription or non-prescription may be administered to my child unless the situation is life-threatening and emergency treatment is required.

**(4) Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

I hereby grant permission for non-prescription medication (such as aspirin, throat lozenges, cough syrup) to be given to my child, if deemed advisable.

**(5) Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Specific Medical Information: OYM, 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: \_\_\_\_\_

Medications child currently takes \_\_\_\_\_

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

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

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting? \_\_\_\_\_

Has child recently been exposed to contagious disease or condition, such as mumps, measles, chicken pox, etc.? \_\_\_\_\_

If so, date and disease or condition: \_\_\_\_\_

You should also be aware of these special medical conditions of my child \_\_\_\_\_

I fully understand the consequences of the foregoing statements and sign this **PARENTAL/GUARDIAN CONSENT FORM AND LIABILITY WAIVER** knowingly, freely, and willingly. **(Your signature must appear below or your child will not be permitted to attend the "Program")**

**(6) Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_