"Msgr. Sabourin Vacation Bible Camp"
Registration 2019
St. Patrick Church
Office of the Apostolate for People with Disabilities

Today's Date: _____

Camper Name: _____

Birth Date (Day / Month/ Year)_____Age_____ Male _____ Female _____

Mother: _____

Address: _____ City/State/Zip: _____

Phone (home): _____ (mobile): _____ (other) _____

Mother Email: _____

Father: _____

Address: If different from mother _____ City/State/Zip: _____

Phone (home): _____ (mobile): _____ (other) _____

Father Email: _____

Brothers/Sisters (names): _____

Parish/Town: _____ Registered? Yes___ No__

Camper Allergies / type / food / Restriction: (If none – please indicate none)

_____

_____

Camp Cost: $30.00/ per person

For office use
Payment Received Date:_____ Check (Number)/ Cash/ Money Order: _____
Received By: _____

Background Information – If it does not apply please write none

Diagnosis or description of special needs *(dual?)*: _____

_____

Physical Needs: _____

Communication Skills (verbal/nonverbal): _____

Corrective Aids: _____

Toileting Routine: _____

Fears/Phobias: _____

Enjoyable Activities: _____

Frustrating Activities: _____

Behavior Triggers: _____

Behavior Programs: _____

Calming Techniques if over excited: _____

Independent Skills: _____
(Dress up, cutting, folding, tie shoes…)

Touch, Light, Sound or… Sensitivities: _____

Relationships:
Any comments regards how does he/she prefers to interact with other people (if you feel there is something we should know to make his time with us enjoyable)

_____

_____

_____

Please complete and sign these forms: 1) Medical Emergency Information 2) Photo-Electronic Media Release Form

Other Comments: _____

_____

Parent(s)/Guardian: _____ Date: _____
PRINT and Signature

_____

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Medical Emergency Information & Contact

Camper Name: _____

Birth Date (Day / Month/ Year)_____Age_____ Male _____ Female _____

In case of Emergency, Please notify:

Primary Contact: _____ PHONE (H) _____

Relationship to person: _____ PHONE (C) _____

Secondary Contact: _____ PHONE (H) _____

Relationship to person: _____ PHONE (C) _____

Medical Diagnosis / Disability or Medical concerns you want us to know in an emergency:

_____

Medications (Optional) _____

Allergies / type /food/ Restriction: (If none – please indicate none)

Seizures? No _____ Yes_____ Describe_____
_____

Other Comments:_____

EMERGENCY MEDICAL TREATMENT: In the event of any emergency, I give permission to transport my child to the nearest hospital for emergency medical treatment. Or I prefer camper to be transported (if allowed) to: _____
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: _____ **Phone Number: _____**

Parent(s)/Guardian: _____ Date: _____
PRINT and Signature

_____

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PARENT/LEGAL GUARDIAN/VOLUNTEER
PERMISSION SLIP AND INDEMNITY AGREEMENT

Your son/daughter, ward, yourself _____, is eligible to participate/volunteer in the Office of the Apostolate for People with Disabilities of the Diocese of Providence and St. Patrick Church sponsored activity that requires permission.
This activity will take place under the guidance and supervision of volunteers from the Office of the Apostolate for People with Disabilities of the Diocese of Providence and St. Patrick Church.

A brief description of the activity is as follows:

TYPE OF ACTIVITY: Vacation Bible Camp at St. Patrick
DESCRIPTION OF ACTIVITY: Bible Stories, Crafts, Games, Songs and Holy Mass, All at St. Patrick Church
DATE AND TIME OF ACTIVITY: June 24 – 28, 2019
METHOD OF TRANSPORTATION: Drop off at St. Patrick Church in the morning 9:30 am And pick up 1:30 pm by family member
CAMP COST: $30.00 per person

I would like my child/ward/self to participate in this activity. As parent or legal guardian or self, I agree to defend and fully indemnify St. Patrick Church, the Office of the Apostolate for People with Disabilities and Diocese of Providence (Parish/School/Office/Diocese) against any claim, which may result from any personal actions taken by my child/ward/self. As parent or legal guardian or self I further agree to fully indemnify and hold harmless St. Patrick Church, the Office of the Apostolate for People with Disabilities and Diocese of Providence against any claim or cause of action whatsoever brought against St. Patrick Church, the Office of the Apostolate for People with Disabilities and Diocese of Providence which took place during the above-identified activity, which is related to that activity, if that claim or cause of action is brought by my child/ward/self or their parent/legal guardian.

I hereby consent to participation by my above-named child/ward/self in the activity described above. I certify that I have an understanding of this agreement and the activity described above that my child/ward/self will be participating in. I further understand that I had the opportunity to fully discuss the above-named activity and this agreement with a representative of this parish/school/office to clarify any concerns or questions about the activity or this agreement that I may have had.

_____ _____
Parent/Legal Guardian Name PRINT **Date**

_____ **Phone Numbers**
Signature

(H)_____ **(W)** _____

_____

(M) _____

_____
Address