THE ORIGINAL CAMP ReCREATION
OF CATHOLIC CHARITIES OF ORANGE COUNTY SINCE 1978

Hello to our Amazing Camp Family!

It's finally that time again – camp recruitment!!! **This year we plan to celebrate Camp ReCreation JR. (kids ages 4-17) in June and Camp ReCreation (adults 18+) In July**. We will celebrate both Camp ReCreation JR. (RC JR) and Camp ReCreation (RC) at Vanguard University located at 55 Fair Drive Costa Mesa, CA 92626.

You will be greeted by our excited volunteers at your assigned arrival time on **Thursday June 27th with pick up on Sunday June 30th for ReCreation Jr. While Camp ReCreation drop-off will be held Sunday July 7th and pick up will occur on Wednesday July 10th.**

This year, we are asking for your help to accommodate our continued success at Camp! Thanks to the generous contributions from the Knights of Columbus, Catholic Charities and the local community, we have been able to offset many of the costs of the new venue and increased costs. However, we need your help! In order to continue to offer camps throughout the year, to the same amount of people, we are asking for a donation fee of $50-$200. Please make your check payable to Catholic Charities OC directed towards RC JR or RC with your camper name in the Memo. **This is a suggested donation**. If you are unable to make a donation, please still register your Buddy. No camper will be turned away because they are unable to donate.

In order to reserve your spot for camp, we ask that you send your **COMPLETE** application forms to Camp Headquarters at the address below. Once we receive the COMPLETE application your camper will be placed on the registration list. Please note this is different than in years past. **All paperwork must be completed, including the medical release in order to reserve your campers spot. Spots are filled on a first come first served basis.**

If you have any questions, you can contact us by e-mail at CAMP@ccoc.org or by calling 714.347.9627. Please don't delay registering for this amazing event!

**Registration deadline is May 1, 2019!!**

**Applications will be processed on a first come first serve basis.**
**Please return your application form as soon as possible to**:

**Camp ReCreation**
**Attn: Camper Registration**
**1820 E 16th Street**
**Santa Ana, CA 92701**

We look forward to seeing you and welcoming you back to Camp ReCreation!!!

Madeline "Madie" Dibb-Fugate, B.A.

Teresa "Tita" Smith, MSW, LCSW

THE ORIGINAL CAMP ReCREATION OF CATHOLIC CHARITIES OF ORANGE COUNTY SINCE 1978

# CAMPER APPLICATION FORM 2019

**PHOTO HERE!!**

**WILL NOT BE RETURNED**

**Please circle the camp you are applying for:**

**ReCreation (18+ years old) July 7-10, 2019** **RC Jr. (4-17 years old) June 27-30, 2019**

**NAME OF CAMPER** _____

**GENDER** _____ **AGE** _____ **DOB** _____ **Years at Camp**_____

**NAME OF PARENT(S)/GUARDIAN(S)** _____

**Relationship to Camper** _____

**PHONE** _____

**ADDRESS** _____
**Street address**

_____
**City** **State** **Zip**

**EMAIL** _____

**NAME OF GROUP HOME (If applicable)** _____

**CONTACT PERSON** _____

**ADDRESS** _____
**Street address**

_____
**City** **State** **Zip**

**PHONE** _____

**EMAIL** _____

**I WOULD LIKE INFORMATION SENT TO:**
☐ **MY ADDRESS** ☐ **THE GROUP HOME ABOVE (If applicable)**

**IN CASE OF EMERGENCY WHILE AT CAMP, PLEASE CONTACT:**
☐ **PARENT** ☐ **GROUP HOME** ☐ **EMERGENCY CONTACT BELOW**

**EMERGENCY CONTACT NUMBERS:**
**In the event of an emergency, please list 2 persons to contact who know your camper and would be able to assume full responsibility if you are not available or cannot be reached.**

**1.**_____
**Name** **Relationship** **Home #** **Cell#**

**2.**_____
**Name** **Relationship** **Home #** **Cell#**

**CAMPERS NAME:** _____

**T-SHIRT SIZE:** **S** **M** **L** **XL** **XXL** **XXXL**
**TYPE:** **Youth** **Adult**

**DOES THE CAMPER HAVE ANY OF THE FOLLOWING? PLEASE CIRCLE.**

| | |
|---|---|
| **SEIZURES** | **YES / NO** |
| **HEART PROBLEMS** | **YES / NO** |
| **VISUAL IMPAIRMENT** | **YES / NO** |
| **HEARING IMPAIRMENT** | **YES / NO** |
| **SLEEPING DIFFICULITIES** | **YES / NO** |
| **BEHAVIOR DIFFICULITIES** | **YES / NO** |

**COMMENTS ON ANY OF THE ABOVE** _____

_____

**OHER (Please Describe)** _____

_____

**CAN THE CAMPER WALK WITHOUT ASSISTANCE?** **YES / NO**

**IF NO, PLEASE NAME ITEMS NEEDED FOR TRANSPORTATION AND/OR MOBILITY** _____

_____

**DOES CAMPER REQUIRE A SPECIAL DIET?** **YES / NO**

**IF YES, PLEASE EXPLAIN** _____

_____

**HAS HE OR SHE RECEIVED FIRST COMMUNION?** **YES / NO**

**SIGNATURE OF PARENT OR LEGAL GUARDIAN IS REQUIRED.**

**Guardian** _____ **DATE** _____

**PLEASE WRITE A FEW PARAGRAPHS ABOUT YOUR CAMPER THAT MIGHT HELP THE VOLUNTEER IN UNDERSTANDING HIM OR HER.**

***PLEASE INCLUDE ANY HABITS YOU ARE TRYING TO BREAK OR SKILLS YOU ARE TRYING TO LEARN TO BE ENFORCED AND/OR ENCOURAGED AT CAMP.***

***ALSO, PLEASE UPDATE US ON ANYTHING THAT IS NEW OR HAS CHANGED SINCE THE PREVIOUS YEAR'S APPLICATION.***

# *Camper Health History, Immunizations & Medications 2019*

Name of Camper: _____

Disability: _____

**Does the participant have a history of the following? Give approximate dates:**

| | | | |
|---|---|---|---|
| Ear Infection | _____ | Allergies: | |
| Rheumatic fever | _____ | Insect Stings | _____ |
| Seizures | _____ | Epi pin | _____ |
| Diabetes | _____ | Penicillin | _____ |
| Chicken Pox | _____ | Poison Ivy | _____ |
| Measles | _____ | Latex | _____ |
| Hay fever | _____ | Other | _____ |
| Mumps | _____ | | |
| Asthma | _____ | | |
| Positive TB Test | _____ | | |

**Immunizations: (Must be current up to date; give most recent date)**

| | | | |
|---|---|---|---|
| DPT | _____ | Tetanus | _____ |
| TB Skin test | _____ | Polio | _____ |
| Mumps | _____ | Measles | _____ |
| Rubella | _____ | | |
| | | Other | _____ |

Operations or other serious injuries, include dates: _____

_____

Chronic or recurring Illness (es): _____

_____

Other diseases/ailments or more details from statements above:

_____
_____
_____
_____
_____
_____
_____
_____
_____

# *Medication 2019*

Physicians may find it necessary to prescribe medication during the time your son/daughter is at camp. Such medication ***MUST BE IN IT'S ORIGINAL CONTAINER*** with the participant's name, the name of the prescribing doctor, and the name and dosage of the medication. All over the counter medications, ointments, vitamins, etc must also be listed with the dosage and must be turned into the nurse during check in on the first day of camp.

Medications for (Name of Camper): _____

Name of Medication Dosage Time of Day

1. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____
2. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____
3. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____
4. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____
5. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____
6. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____
7. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____
8. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____
9. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____
10. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____
11. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____
12. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____

Other PRN medications

1. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____
2. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____
3. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____
4. _____ _____ Breakfast ____ Lunch ____ Dinner ____ Bed____

*****I, _____ hereby authorize Camp ReCreation Medical Personnel to administer medications in accordance with the above descriptions to my camper, _____.*****

**Signature:**_____ **Date:**_____

# *CONSENT FORM*

**CONSENT TO ATTEND SUMMER CAMP 2019:**

We hereby give our consent for our son/daughter/brother/sister to attend ReCreation Summer Camps.

Yes / No

**CONSENT TO ADMINISTER/RECEIVE MEDICATIONS:**

We hereby give our permission for the Registered Nurse/Camp Administrators of ReCreation/RC Jr. Summer Camp to administer medications to our son/daughter/brother/sister as prescribed. This consent also applies to non-prescription drugs/medications such as Tylenol, Advil or other PNs, except as noted below.

Yes / No

**EXCEPTIONS**:_____

**CONSENT FOR PHOTOGRAPHS & VIDEO:**

We hereby give our consent to Catholic Charities of Orange County to photograph and/or video our participant and to use such images and/or stories in connections with promotional materials of any kind. We also do hereby release said ReCreation Camp and Catholic Charities of Orange County for any claims whatsoever which may arise in such regards.

Yes / No

**In signing below, we do hereby give consent to the above terms.**

Caregiver/Guardians Signature:_____ Date:_____

# *Medical and Dental Information 2019*

Name of Participant: _____

Medical or Medical Number: _____

Private Insurance Phone Number: (  ) _____

Policy Number: _____ Group Number: _____

Allergies to Medications: _____

_____

**Allergic to Latex: YES NO**

## *Physicians*

Name: _____ Phone: (  )_____

Address: _____

_____

Name: _____ Phone: (  )_____

Address: _____

_____

## *Dentist*

Name: _____ Phone: (  )_____

Address: _____

_____

# *Authorization for Medical Care 2019*

***For minors <u>under age 18</u> and adults with court –appointed guardians.***

(I) (We), the undersigned, parent(s) or guardian(s) of _____, do hereby authorize the Diocese of Orange and Catholic Charities of Orange County, Inc. as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical, surgical or dental diagnosis and treatment and hospital care which is deemed advisable by, and is rendered under the general or special supervision of any physician, surgeon or dentist licensed under the provisions of the Medical Practice Act or the Dental Practice act, and selected by the aforesaid agent(s), whether such diagnosis or treatment is rendered at the office of a physician, dentist, hospital or other health facility.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required and is given as a precautionary measure to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician, surgeon, or dentist in the exercise of his/her best judgment may deem advisable. It is further understood that the aforesaid agent(s) will make every effort to contact the parent(s)/guardian(s) in the event of emergency or extensive treatment prior to authorizing such treatment. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

It is understood that the above named agent(s) assumes no liability of any kind or character, financial or otherwise, for acting pursuant to the above authorization.

This authorization shall be in effect as long as the above-named client remains in the care of the aforesaid agent(s), unless sooner revoked in writing delivered to said agent(s).

A photocopy of this authorization is as valid as the original.

PLEASE SIGN BELOW:

Legal Guardian _____ DATE: _____

# 2019 MEDICAL EXAMINATION

***TO BE FILLED OUT BY A LICENSED PHYSICIAN – 2 pages***

Participant's Full Name _____

DOB _____ AGE _____

This examination form should be filled out within 12 months of the last day of camp. Examination for some other purpose within those named 12 months is acceptable. Examination is for determining fitness to engage in strenuous activities.

Ht. _____ Wt. _____ BP: _____ Urinalysis: _____

**Code: S=Satisfactory NS=Not Satisfactory X=Not Examined**

| | |
|---|---|
| Eyes | _____ |
| Glasses | _____ |
| Ears | _____ |
| Skin | _____ |
| Nose | _____ |
| Throat | _____ |
| Teeth | _____ |
| Lungs | _____ |
| Abdomen | _____ |
| Extremities | _____ |
| Posture (spine) | _____ |
| Hernia | _____ |
| Allergy (specify) | _____ |

**General Appraisal _____ Heart _____

**Immunizations: (Must be current; give most recent date)**

| | | | |
|---|---|---|---|
| DPT | _____ | Chest X-Ray | _____ |
| Tetanus | _____ | TB Skin test | _____ |
| Polio | _____ | AU Antigen test | _____ |
| Measles | _____ | Rubella | _____ |
| Mumps | _____ | Other | _____ |

**For Ladies:**

| | |
|---|---|
| Has the person menstruated? | YES / NO |
| If not, has she been told about it? | YES / NO |
| If yes, is her menstrual history normal? | YES / NO |
| Will she have her period at camp? | YES / NO |
| Special considerations: | YES / NO |

If yes, _____

## TO BE FILLED OUT BY A LICENSED PHYSICIAN…Continued

### RECOMMENDATIONS AND RESTRICTIONS AT CAMP 2019

Special diet: YES / NO

If yes, _____

Medications: YES / NO

If yes, please name _____

Is the parent/guardian sending the medication(s)? YES / NO

***Other:***

Swimming? YES / NO
Heavy walking? Strenuous activity? YES / NO
Stairs? YES / NO
Noise? YES / NO
Ear Plugs necessary? YES / NO
Strobe Lights? YES / NO

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to participate in the camp activities, except as noted above.

Examining Physician Name _____ Date _____

Signature _____

Address _____ Phone _____

_____

# *Camper Agreement 2019*

Participation in ReCreation Camp, RC Jr., and our day events are a privilege we hope our camper's enjoy. For the welfare of the campers, as well as the entire camp community, it is essential that you read, understand and agree to support the provisions of this agreement.

My camper will (and I will support):

- To show respect for all campers and the camp community
- To refrain from profanity or indecent language.
- To refrain from the use of cell phones, computers, iPods, etc. except when allowed by my Team Leader or the Directors
- To respect the personal property of campers, camp facilities, counselors and staff members.
- To cooperate with the Camp Director, Nurses, Team Leaders and other staff members.
- To remain on campgrounds unless you have received special permission from the Camp Director to leave for some serious and necessary reason.
- To refrain from physically touching, hitting, biting or hurting fellows campers and counselors, and I understand if something like this does happen, I will be warned and then possibly asked to leave camp based on the decision by the director
- Upon my arrival, I understand I will have to check in immediately with a nurse. If my vitals show any sign of concern, I will be asked to leave camp and will only be allowed to return with doctor's authorization.
- **If I have any symptoms of a cold or flu within 48 hours prior to camp, I will call the director as soon as possible to discuss my role at camp.**
- I understand that I need to sleep at night and take care of my own physical and mental well-being. I know that if I start to feel as if I need a mental break or nap, all I need to do is ask.

I (we) the undersigned, parent(s) or guardian(s) of _____, agree to support the provisions of the Camper Agreement as stated above to the best of my ability. I understand that if my camper violates any of the provisions of this agreement they are subject to dismissal. I also understand that Catholic Charities reserves the right, to re-invite my camper back next year based on their behavior at camp by way of evaluations and my compliance with the Camper Agreement.

_____

Signature of parent / guardian Date

Catholic Charities of Orange County
ReCreation, and RC Jr. Camps
**Participant Permission and Release 2019**

*Event/Program:* _____

*Location:* _____

*Date(s) and Time:* _____

*Participant's Name:* _____ *Date of Birth* _____

*Participant's Residence Address:* _____

*Parent/Guardian Name:* _____ *Phone #:* _____

*Other Emergency Contact Name:* _____ *Phone #:* _____

*Family Physician:*_____ *Phone #:* _____

*Insurance Company:* _____ *Policy #:*_____

*Allergies/Medical Problems/Disabilities:* _____

I, the Parent/Guardian of _____ hereby give my permission for her/his participation in the above named event. I agree to direct my child/ward to cooperate to the best of his/her abilities with the direction and instructions of the event Directors, Team Leaders and Staff.

As a condition of my child's/wards opportunity to participate in this event, I hereby release Catholic Charities of Orange County, ReCreation, ACE and RC Jr. Camps, the Diocese of Orange, The Roman Catholic Bishop of Orange, a corporation sole, The Knights of Columbus and all of their directors, officers, employees and volunteers from any and all claims for personal injuries or property damage that (s)he may suffer as a result of participation in this event, whether or not such injuries or damages are caused by the negligence, active or passive, of any of the entities and individuals named or described above.

I agree that in the event of an injury to my child/ward as a result of his/her participation in this event, whether or not caused by the negligence, active or passive, of the entities and individuals herein named or described, recourse for the payment of any resulting hospital, medical or dental treatment or related costs and expenses will be against any accident, hospital, medical or dental insurance or any available benefit plans for my child/ward. I am not aware of any medical condition of my child which would render it inadvisable for him/her to fully participate in this event's activities other than:
_____.

I hereby authorize the making of photographs, motion pictures, video tapes, recordings or other memorializing of this event and my child's/ward's participation therein, and the publication and duplication or other use thereof. I hereby waive any rights to compensation or any right that I otherwise might have to limit or control such making or use.

I hereby give permission to the physician, nurse, dentist or licensed care staff selected by the supervisory personnel then present to render medical, dental or other appropriate treatment deemed necessary by the physician, nurse, dentist or licensed care staff.

*Parent/Guardian Signature:* _____