

DIOCESE OF BAKER SUMMER CAMP 2010

ADULT HELPER/CHAPERONE APPLICATION FORM

Please mail your Application Form & Liability Waiver by the deadline to the Diocese of Baker so that we can verify that you have completed a Background Check, Darkness to Light and Code of Conduct.

Mail to: Diocese of Baker • Attn: Patti Rausch
PO Box 5999 • Bend, OR 97708

- | | |
|--|---|
| <input type="checkbox"/> High School Kick Back Camp
June 20 - 25, 2010
Deadline: May 21, 2010 | <input type="checkbox"/> Family Camp
July 2 - 5, 2010
Deadline: June 4, 2010 |
| <input type="checkbox"/> Leadership Camp
July 13 - 17, 2010
Deadline: June 18, 2010 | <input type="checkbox"/> Middle School Life on Fire Camp
July 17 - 21, 2010
Deadline: June 18, 2010 |
| <input type="checkbox"/> Upper Elementary TYG Camp
August 10 - 13, 2010
Deadline: July 9, 2010 | <input type="checkbox"/> YAK Camp
August 22 - 27, 2010
Deadline: July 23, 2010 |

Name _____ M _____ F _____
Please Print

Address _____

City _____ State _____ Zip Code _____

Phone _____ Cell Phone _____

Email _____

Date of Birth _____

Parish _____ City _____

Signature Date _____

I would like to Thank you in advance for volunteering to help at our Summer Camps. I know first hand how much time and effort you are sharing with our Youth of the Diocese and how much they appreciate your help. *Fr. James A. Radloff*

(please turn over and fill out the Adult Liability Waiver)

ADULT LIABILITY WAIVER

Each adult participant, including group leaders and chaperons, must sign this form.

RELEASE OF LIABILITY/MEDICAL RELEASE

I, _____, agree on behalf of myself, my heirs, assigns, executors, and
Full Name
personal representatives, to hold harmless and defend The Roman Catholic Bishop of the Diocese of Baker, Inc., its officers, directors, agents, employees, or representatives from any and all liability for illness, injury or death arising from or in connection with my participation in the event.

In the event that I should require medical treatment and I am not able to communicate my desires to attending physicians or other medical personnel, I give permission for the necessary emergency treatment to be administered. Please advise the doctors that I have the following drug allergies:

_____;

and dietary allergies and restrictions: _____.

In case of an emergency and for permission for treatment beyond emergency procedures, please contact:

Name: _____ Relationship to me: _____

Daytime Phone: _____ Night time Phone: _____

Cell Phone: _____ Health Insurance Carrier: _____

Insurance ID Number: _____ Insurance Policy Number: _____

Signature

Date

Print Name