CONQUEST

FORGED IN VIRTUE. CALLED TO SERVE.

Camp Bocamb 2015 June 1-7, 2015

81495 Hwy 437, Covington, LA 70435 for boys ages 10 and up

Track 1 for rising 5th –8th graders. Track 2 for boys rising 9th—12th graders.

Sacraments, Sports, Wolf, Great Food, Capture the Flag, Friendships, Fun, Obstacle Course, mini-Olympics...

Bring: rosary, Bible, bathing suits, towels, clothes that can get dirty from extreme games, sports shoes, bug repellant, dress clothes for Mass, sleeping bag, pillow, toiletries, water bottle, backpack, sunscreen.

Leave Behind: All electronics, cell phones and pocket knives.

Fundraising!
Inquire about our raffle to raise money for summer camp!
Contact Martha Lindley at (504)452-1529 or mfl33184@yahoo.com.

Check out pictures from Bocamb 2014: www.facebook.com/conquestlouisiana.

Camp Registration: $400 early, $440 late

A $100 non-refundable deposit made payable to Mission Network is due with the registration by March 21 to:
Martha Lindley, 385 Sioux Dr., Abita Springs, LA 70420.
$300 early registration balance due by April 15.
Arrive 5pm, Monday, June 1st.
Concludes beginning with Mass Sunday, June 7th, @11am.

Mission Network
SERVING THE CHURCH

Regnum Christi Youth Programs

LEGIONARIES OF CHRIST

Registration Information

Name:_____

StreetAddress: _____

City_____ State_____ Zip_____

Phone_____

Email_____

School and Grade _____

Date of birth _____ Age _____

T-shirt size adult small_____ adult medium _____ adult large _____

adult ex-large _____

Church Parish _____

Diocese _____

Do you attend a Parish School of Religion (PSR)? ____Yes ____ No

Dads are needed to chaperone**.** A local leader will contact you.

Father's Name_____

Phone_____

Safe Environment Training completed _____Yes _____No

Background Check completed _____Yes _____No

Dad can attend the following days: June 1 ___ June 2 ____ June 3_____ June 4 _____
June 5 _____ June 6 ____ June 7 _____

ADDENDUM FOR: Bocamb Farm

Covington, Louisiana

1. CHILD'S NAME:_____

2. ACTIVITY: Bocamb 2014 Summer Camp for boys grades 5-9

3. DURATION OF ACTIVITIES: June 1-7, 2015

4. ACTIVITY SUPERVISOR(S): Fr. Robert DeCesare LC, Fr Jacob DuMont LC, Hunter Winans, and adult Conquest representatives

5. INSURANCE: I/We understand that **Bocamb Farm** does not carry any insurance relative to the activities or for any injury that may occur to the above-named child. I/We represent that the child is covered by insurance through my own insurance carrier.

6.RELEASE AND INDEMNIFICATION: I/We release and waive, and further agree to indemnify, hold harmless or reimburse **Bocamb Farm** against any claim which I, any other parent or guardian, any sibling, the above-named child, or any other person, firm or corporation may have or claim to have, known or unknown, directly or indirectly, for any losses (including attorneys' fees incurred by **Bocamb Farm** or any of its owners, employees, agents, volunteers, etc. in enforcing this indemnity provision without limitation in time or amount, damages or injuries arising out of, during, or in connection with the child's participation in the activities, the travel to and there from, and the rendering of emergency medical procedures or treatment, if any. I/We understand that this release and indemnification shall survive the end of my child's participation in the activities at **Bocamb Farm** referenced on this form.

I/We have read and understand the above.

DATE:_____

_____ _____

Parent/Guardian Parent/Guardian

PERMISSION TO PARTICIPATE IN ACTIVITIES
2014-2015 MISSION NETWORK ACTIVITIES USA, INC.

1. **CHILD'S NAME:** _____ **CHILD'S BIRTHDATE:**_____ **GRADE IN SCHOOL:** _____

2. **NATURE AND DURATION OF ACTIVITIES:** June 1-7, 2015 Camp Bocamb. Prayer, Mass, Virtue talks, sports, games, skits, bonfire, night games, faith survey, Olympics, dynamic activities.

3. **ACTIVITY SUPERVISOR(S):** Fr Robert DeCesare, LC; Fr Jacob DuMont LC, Hunter Winans, and adult Conquest volunteers.

4. **TRANSPORTATION**: Not Applicable. Participants are responsible for securing their own transportation to and from activities, as the company does not provide transportation.

5. **MENTORING:** Participants may be offered mentoring, which is intended to help young people personalize the principles of Christian living that they receive at home and in club activities. Mentoring involves a private conversation with an adult conducted in plain view of others. When dealing with adolescents, confidentiality will be maintained to foster an openness of dialogue, but situations involving sexual abuse of a minor or threats to life or physical health will be reported to the appropriate authority and to the parents (except in those cases where the parent may be the alleged abuser.

6. **REQUIREMENTS:** The child named above is in good health and has no physical or medical limitations that would cause the activities as described above to be detrimental or dangerous to the child. Parents/guardians should specify allergies and medical problems in section 9 below.

7. **CONSENT:** I/We hereby consent to the above-named child's participation in the activities described above including mentoring, and specifically request that he be allowed to participate in those activities. I/We warrant that I/We have full authority to legally consent to his participation in the activities described on this form, and all provisions contained herein.

8. **AUTHORIZATION.** I/We hereby authorize Mission Network Activities USA, Inc. to use the image and likeness of my/our child in photograph or video form whether taken by or commissioned by Mission Network Activities USA, Inc. in its promotional materials and for its promotional purposes associated with its nonprofit activities. This authorization shall extend to use of my/our child's image and likeness on the website of Mission Network Activities USA, Inc., or its successor in operation or affiliated organization(s) upon written consent of Mission Network Activities USA, Inc. I/We understand that this
authorization shall survive the end of my/our child's participation in the activities referenced on this form.

9. **INSURANCE:** I/We understand that Mission Network Activities USA, Inc. does not carry any health insurance relative to the activities or for any injury that may occur to the above-named child. I/We represent that the child is (a) covered by insurance through my/our own insurance carrier; or (b) that I/We am/are personally financially responsible for any and all medical costs incurred as a result of the child's injury.

10. **EMERGENCIES**: If the above-named child requires any emergency medical procedures or treatments during the activities, I/We consent to the activity
supervisor(s) taking, arranging for or consenting to such procedures or treatments in the discretion of the activity supervisor(s). For purposes of such procedures and treatments, my/our child's blood type allergies or other medical problems (if any) are listed below:

Blood Type: _____ Allergies / Medical Problems:
_____

_____

11. **EMERGENCY CONTACTS:** If, in the event of a medical or other emergency, I/We am/are unable to be reached by telephone at the numbers listed below, I/We authorize the activity supervisor(s) to attempt to contact me/us through the alternative emergency contacts listed below.

Parents/ Guardians Contact Information

Name: _____ Email: _____

Address: _____

Home Phone:_____ Alternate Phone: _____

Name: _____ Email: _____

Address: _____

Home Phone:_____ Alternate Phone: _____

Alternative Emergency Contact Information

(1) Name:_____ Relation: _____

Home Phone:_____ Alternate Phone: _____

(2)) Name:_____ Relation: _____

Home Phone:_____ Alternate Phone: _____

12. **RELEASE AND INDEMNIFICATION:** I/We release and waive, and further agree to indemnify, hold harmless or reimburse Mission Network Activities USA, Inc. and Consolidated Catholic Administrative Services, Inc., the individual members, agents, directors, officers, employees, volunteers and representatives thereof, as well as activity supervisors, from and against, any claim which I, any other parent or guardian, any sibling, the above-named child, or any other person, firm or corporation may have or claim to have, known or unknown, directly or indirectly, for any losses (including attorneys' fees incurred by Mission Network Activities USA, Inc. and Consolidated Catholic Administrative Services, Inc., or any of its individual employees, agents, volunteers, etc. in enforcing this indemnity provision) without limitation in time or amount, damages or injuries arising out of, during, or in connection with my/our child's participation in the activities, the travel to and there from, and the rendering of emergency medical procedures or treatment, if any. I/We understand that this release and indemnification shall survive the end of my/our child's participation in the activities referenced on this form and shall have no limitation in time or amount.

I/We have read and understand the above and agree to all terms and conditions contained therein.

DATE: _____

_____ _____
Parent / Guardian Name Parent / Guardian Name

_____ _____
Parent / Guardian Name Parent / Guardian Name

AUTHORIZATION TO GIVE MEDICATION

MEDICATION TIME SCHEDULES SHOULD BE SET SO THAT, WHEN POSSIBLE, MEDICINE IS TAKEN AT HOME RATHER THAN AT CLUB ACTIVITY. HOWEVER, IF MEDICATION MUST BE GIVEN DURING CLUB ACTIVITY HOURS, THIS FORM MUST BE COMPLETED.

Please complete

MEMBER NAME _____ BIRTH DATE _____

I REQUEST THAT THE MISSION NETWORK ACTIVITIES USA, INC. CLUB VOLUNTEER ASSIST IN ADMINISTERING THE FOLLOWING MEDICATION TO MY CHILD. I UNDERSTAND THAT:

PRESCRIPTION MEDICATIONS MUST BE AUTHORIZED WITH A PHYSICIAN SIGNATURE AT THE BOTTOM OF THIS FORM. PRESCRIPTION MEDICATIONS WILL NOT BE ADMINISTERED WITHOUT PHYSICIAN CONSENT.

OVER THE COUNTER MEDICATIONS REQUIRE PARENT AUTHORIZATION ONLY.

- **Medications must be in the original labeled container (no baggie, foil, etc.). Pharmacists can provide a duplicate labeled container.**
- **Parent/guardian must provide the medication, related equipment required and specific instructions. The student may NOT bring these materials to camp or Mission Network Activities USA, Inc. Activities.**
- **Medication changes or dosage changes must be noted on a NEW medication authorization form. It is the responsibility of the parent/guardian to inform the Mission Network Activities USA, Inc. Club Volunteer of any changes.**
- **New medication or dosage changes will not be given unless a newly labeled container is provided.**
- **Unused medication will be disposed of unless picked up within one week after medication is discontinued.**

Medication will be administered as follows:

NAME OF MEDICATION _____

Dose _____ Administration Time(s) _____

Route (by mouth, topical, etc.) _____ Stop medication on _____

Symptoms in which child may require medication as necessary _____

_____

Condition/Illness requiring medication _____

Additional equipment required for administration _____

Possible side effects _____

Physician's name _____ Phone _____

I authorize the administration of the above stated medication while following under these directions:

_____ _____

PARENT SIGNATURE (FOR ALL MEDICATIONS) Date

_____ _____

PHYSICIAN SIGNATURE (FOR PRESCRIPTON ONLY) Date

Mom's Name _____ Dad's Name _____

Mom's Cell/Home _____ Dad's Cell/Home _____

In consideration for receiving permission to participate in the activities of Mission Network Activities USA, Inc., N.A., Inc., I hereby RELEASE, WAIVE, DISCHARGE AND COVENANT NOT TO SUE, Mission Network Activities USA, Inc. N.A., Inc., its officers, agents, servants, employees or volunteers (hereinafter referred to as RELEASES) from any and all liability, claims, demands, actions and causes of action whatsoever arising out of or related to any loss, damage, or injury, including death, (Including, but not limited to death or injury arising from dispensing of the above medications by releases to the above member) that may be sustained by me, or any child or guardian of me, or any of the property belonging to me, WHETHER CAUSED BY THE NEGLIGENCE OF THE RELEASEES, or otherwise, while participating in such activity, or while in, on or upon the premises where the activity is being conducted.

A Medication Authorization Form must accompany each medication

Please make additional copies as needed