

CAMP R.O.C.K.

Join us for 4 days of:

**SWIMMING
CANOE TRIP
PRAYER
ARCHERY
SMALL GROUPS
BONFIRE
INDOOR GYM
CLIMBING WALL
LIVE BAND
WATER SLIDE
SPORTS
OBSTACLE COURSE
TALKS & SKITS
MASS
RECONCILIATION
CRAFTS
AND SO MUCH MORE!**

CAMP R.O.C.K. 2010

What: It's a 4 Day, 3 Night Summer camp for Middle School Teens. It is sponsored by Joyful Hope Presentations.

When: **JUNE 12 – 15, 2010**

Who: Any youth currently in 6 – 8 Grade

Where: DICKSON VALLEY CAMP,
NEWARK, IL (NEAR PLANO, IL)

Cost: **\$295.00 ***
*includes \$75.00 non-refundable deposit.



How to Register...

FILL OUT THE REGISTRATION FORMS AND RETURN IT TO:

Joyful Hope Presentations

WITH YOUR \$75.00 NON-REFUNDABLE DEPOSIT

(Payable to Joyful Hope Presentations)

P.O. Box 484 Batavia Il 60510

THE BALANCE OF \$220.00 IS DUE NO LATER THAN APRIL 1, 2010.

QUESTIONS? CALL MARK HERWALDT AT 630-483-4226

REGISTRATIONS WILL BE ACCEPTED BEGINNING ON OCTOBER 1, 2009.
LIMITED SPACES. THEY WILL BE FILLED ON A FIRST-COME, FIRST-SERVE BASIS

CAMP ROCK! 2010

PERMISSION FORM

GENERAL PERMISSION FORM

I request that my child, _____, be allowed to participate in Camp Rock event, located at Dickson Valley Camp, IL on the following day(s): from June 12, 2010 to Sunday, June 15, 2010.

I hereby release and indemnify my parish, _____, its staff, volunteers, and the Diocese of Joliet, Joyful Hope Presentations, and Dickson Valley Camp and Resort from any and all liability arising from claims of any kind or nature whatsoever from my child's participation in this event. Campers are expected to stay during the **entire** camp session and if they must leave for any reason other than a family emergency they should not register for camp.

Videotaping and Still Photographs

Video and still photographs may be taken during this event. This authorization form constitutes permission for my child's participation in the videotape and/or still photographs, which may be used for future promotional efforts, including the Diocese of Joliet website.

Parent/Guardian Signature: _____ Date: _____

Code of Behavior

You are representing Youth Ministry in our diocese during this event and we expect you will represent us well. We expect that you will display mature and responsible behaviour, which for many years has been the trademark of Catholic youth and adults of our diocese.

Some Expectations:

1. All participants are expected to arrive on time.
2. All participants are expected to demonstrate common courtesy and respect at all times. Inappropriate language/behavior will not be tolerated.
3. Socializing should always be done in public areas. NO females are allowed in male dorms. NO males are allowed in female Dorms.
4. Dress should reflect the value of modesty. Writing on clothing should reflect Christian values.
5. The possession or consumption of any alcoholic beverage and/or illegal drug is not permitted including smoking tobacco products.
6. Weapons and/or drug paraphernalia are not allowed.
7. Prescription drugs need to be given to camp nurse for storage and distribution.
8. Infraction of these rules can mean immediate dismissal with no refund. Participants will be responsible to local authorities as well.

I understand and agree to this Code of Behaviour. I also understand and agree that at the time of an infraction requiring my dismissal, I am responsible for my removal from the premises and any costs involved. I also understand and agree that my parents or guardian will be notified at the time of an infraction requiring my dismissal. My parents or guardian will be responsible for my removal from the premises and any costs involved.

Youth Signature: _____ Date: _____

MEDICAL PERMISSION FORM

I grant permission for the administration of First Aid to my child, _____, by the people in charge of Camp R.O.C.K. 2010, and those transporting my child to and from the event as their judgment deems advisable, and to make the necessary referrals to qualified physicians for the treatment of illness or accidents of a more serious nature. I understand I will be promptly notified in the event of any serious illness or accident and prior to any major surgery, except when delay in such communication would endanger life. In the case of a medical emergency, I understand that every effort will be made to contact the parent/guardian of the participant. In the event that I cannot be reached, I hereby give permission to the physicians selected by the adult staff to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery if deemed necessary for my child.

Parent/Guardian Signature: _____ Date: _____

Printed Parent/Guardian Name: _____

CAMP ROCK! 2010
REGISTRATION FORM

Child's Information:

Child's Name: _____
Birth Date: _____
Grade (2009-2010 School Year): _____
Gender: (Please circle One) Male Female
T-shirt Size: (Adult Sizes) Small Medium Large X-Large 2X- Large
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____
Parent's Cell Phone: _____
Parents E-mail: _____
Other Emergency Contact Name: _____
Emergency Contact Phone #: _____
Parish/Church Name: _____

Medical Information:

Allergic to medication/other? (circle one) NO YES

If yes, please describe: _____

Medication(s) presently taking: _____

Authorized Physician Name: _____
Physician Phone #: _____

Insurance Information:

Policy in the name of: _____
Insurance Company: _____
Policy Number: _____
Identification/Social Security Number: _____

**Return this completed form, along with non-refundable deposit of \$75.00
(Check made out to Joyful Hope Presentations) to:

Joyful Hope Presentations
P.O. Box 484
Batavia, Illinois 60510

Call Mark Herwaldt at 630-483-4226 if you have any questions

CAMP R.O.C.K. STUDENT PRESCRIPTION & O.T.C. MEDICATION FORM

Child's Full Name _____ Date of Birth _____

Emergency Contact _____ Contact Phone # _____

***ALL MEDICATIONS (BOTH PRESCRIPTION OR OVER THE COUNTER) MUST BE INDICATED ON THIS FORM. AND MUST BE GIVEN TO THE NURSE AT THE BEGINNING OF CAMP IN THE ORIGINAL CONTAINERS.**

***ALL PRESCRIPTION MEDICATIONS MUST HAVE SIGNED PHYSICIAN CONSENT TO ADMINISTER.**

This Side To Be Completed By Physician:

Name of Medication: _____

Dosage: _____

Time Taken: _____

THIS SIDE FOR OFFICE USE ONLY
(Initial appropriate box(es) after administration of medication.)

	Date:	Date:	Date:	Date:
A.M.				
Noon				
P.M.				
Bed				

This Side To Be Completed By Physician:

Name of Medication: _____

Dosage: _____

Time Taken: _____

THIS SIDE FOR OFFICE USE ONLY
(Initial appropriate box(es) after administration of medication.)

	Date:	Date:	Date:	Date:
A.M.				
Noon				
P.M.				
Bed				

This Side To Be Completed By Physician:

Name of Medication: _____

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Time Taken: _____

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(Initial appropriate box(es) after administration of medication.)

	Date:	Date:	Date:	Date:
A.M.				
Noon				
P.M.				
Bed				

This Side To Be Completed By Physician:

Name of Medication: _____

Dosage: _____

Time Taken: _____

THIS SIDE FOR OFFICE USE ONLY
(Initial appropriate box(es) after administration of medication.)

	Date:	Date:	Date:	Date:
A.M.				
Noon				
P.M.				
Bed				

Allergies: _____

Signature of Person Administering Medication

Physician Signature

() _____
Phone #

Parent Signature

() _____
Phone #

Date

Notes: