



CAMPING HEALTH, CONSENT AND RELEASE FORM FOR NORTHBAY ADVENTURE CAMP ONLY

FOR AREA DIRECTORS

Area # _____
 Area Name _____
 Trip Leader/Area Dir. _____
 Camp Dates _____

Camper Leader A-Team
 Summer Staff Work Crew
 Adult Guest

Information in this document is protected by HIPAA privacy laws and should be handled accordingly.
 This form is only good for travel to and from, and attendance at, this specific camp; it may not be used for any other camping trip. A new form must be completed for each Young Life Camp experience.

Note to Parent/Guardian/Guest: Young Life wants the camp experience to be a safe and healthy one. However, in the event of an accident or illness, it is important that we have the following information:

1. Medical history;
2. Medical insurance information; and
3. Pregnant and Post-Delivery Teens: Pregnant teens up to 34 weeks and teen moms 6 to 12 weeks post-delivery on camp date must have a physician's release. Teen moms less than 6 weeks post-delivery on camp date may not attend. Pregnant teens over 34 weeks to full term are not allowed to attend camp.

Please make a copy for your records. Camps may not fax or send copies to other camps.

Name _____ Email _____
Last First Middle Initial Birthdate Sex Age

Parent or Guardian (or spouse) _____ Cell Phone (____) _____

Home Address _____ Home Phone (____) _____
Street Address City State/Province Zip

Business Address _____ Phone (____) _____

Second Parent or Guardian Emergency Contact _____

Home Address _____ Home Phone (____) _____
Street Address City State/Province Zip

Business Address _____ Phone (____) _____
Street Address City State/Province Zip

If not available in an emergency, notify: Name _____

Home Address _____ Home Phone (____) _____
Street Address City State/Province Zip

Name of School Camper Attends _____

ACCIDENT COVERAGE

I understand that my personal insurance will be primary coverage for camper accidents and that Young Life's insurance is secondary up to a maximum of \$20,000 (\$4,000 for dental claims). Exception: if the total claim is less than \$250, Young Life will pay the full amount. On claims above \$250, Young Life will coordinate payments for deductibles and co-pays. Young Life's policy does not cover camper illnesses. If you have questions, please contact Young Life Benefits and Insurance at (719) 381-1950.

My insurance company _____ Policy Number _____
 Insurance company address/Web Address _____

Not currently insured – Young Life reserves the right to subrogation if it is later determined that personal medical insurance was in place.

Health Care Recommendations: This section must be completed by a physician, nurse practitioner, or physician's assistant for all teen attending any Young Life camp who is pregnant or has given birth within 12 weeks of the camp date. Parent or adult applicant must complete this section if these conditions do not apply.

1. Has the applicant been diagnosed with a medical condition or disease of the blood, respiratory, metabolic, or other system, such as sickle cell disease, COPD/emphysema, etc. that could limit participation at camps with an altitude 7–14,000 feet? Yes No
 If yes, please explain the condition and expected treatments: _____
2. Does the applicant have any additional medical conditions, including those above in #1 which could limit participation in an active camp program regardless of the elevation? Yes No
 If yes, please explain the condition and expected treatments: _____
3. The applicant is authorized to carry an inhaler, epi pen and other emergency medications with them at all times? Yes No

I have examined the applicant within the past 12 months. Date examined _____ Height _____ Weight _____ Blood Pressure _____

Physician Signature X _____ Date _____ Print Name _____
 (Must be obtained within the same calendar year as the camp trip.)

PROVIDE Insurance Information

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DOCTOR SIGN IF NEEDED

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The applicant is under the care of a physician for the following condition(s) _____

Any treatment or medication to be continued at camp (specify dosages) _____

Chronic or recurring illness or medical condition (including behavioral conditions); operations or serious injuries (dates) _____

Explanation of any reported loss of consciousness, convulsion or concussion _____

Any camp activities from which child should be excluded? _____

Name and phone of family physician _____

Name and phone of dentist/orthodontist _____

ALLERGIES and DIETARY RESTRICTIONS (List any food, drug, plant, insect, or other allergies) Note – This information will be shared with appropriate camp staff.

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Shellfish Allergy | <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Other Allergies (Drugs, insects, plants, food, etc.) OR Dietary Restrictions – Describe below: |
| <input type="checkbox"/> Peanut Allergy | <input type="checkbox"/> Soy Allergy | <input type="checkbox"/> No Pork | |
| <input type="checkbox"/> Tree Nut Allergy | <input type="checkbox"/> Milk Allergy | <input type="checkbox"/> Vegetarian | |
| <input type="checkbox"/> Egg Allergy | <input type="checkbox"/> Dairy Intolerance | <input type="checkbox"/> Vegan | |
| <input type="checkbox"/> Fish Allergy | <input type="checkbox"/> Gluten Intolerance | | |

IMMUNIZATIONS	HEALTH HISTORY	
<input type="checkbox"/> Check and date any immunizations the applicant has received, or <input type="checkbox"/> Applicant has not been immunized for: <input type="checkbox"/> medical <input type="checkbox"/> personal <input type="checkbox"/> or religious reasons.	Check if applicant has: <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding/Clotting Disorder <input type="checkbox"/> Convulsions in last 60 days <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy <input type="checkbox"/> Frequent Ear Infections <input type="checkbox"/> Heart Defect/Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Sickle Cell	Has applicant had (include date): <input type="checkbox"/> Chicken Pox _____ <input type="checkbox"/> Measles _____ <input type="checkbox"/> German Measles _____ <input type="checkbox"/> Mumps _____ <input type="checkbox"/> Hepatitis A _____ <input type="checkbox"/> Hepatitis B _____ <input type="checkbox"/> Hepatitis C _____ <input type="checkbox"/> Mononucleosis _____
<input type="checkbox"/> DTaP (Diphtheria, Tetanus, & Pertussis) Date: _____ <input type="checkbox"/> TD (Tetanus and Diphtheria) Date: _____ <input type="checkbox"/> MMR (Measles, Mumps, Rubella) Date: _____ <input type="checkbox"/> Polio (OPV or IPV) Date: _____ <input type="checkbox"/> Hepatitis B Date: _____ <input type="checkbox"/> Varicella (Chicken Pox) Date: _____ <input type="checkbox"/> HIB (Haemophilus influenza B) Date: _____ <input type="checkbox"/> Other Date: _____	<input type="checkbox"/> Currently Pregnant <input type="checkbox"/> Delivered baby in last 12 weeks	Due Date: _____ Delivery Date: _____

PROTECTIVE CUSTODY ARRANGEMENTS

Is there a court order in place that lists certain persons who are or are not authorized to pick up your child from camp? YES NO

The following people are allowed to pick my child up from camp _____

The following people are NOT allowed to pick my child up from camp _____

Signature of parent/guardian _____ Date _____

AUTHORIZATION FOR TREATMENT

This health history is correct to the best of my knowledge, and the person herein named has permission to engage in all camp activities except as noted. I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to maintain and/or release any medical records necessary for insurance purposes as outlined under the HIPAA regulations; and to provide or arrange necessary related transportation for me or my child. In an emergency, I hereby give permission and authorize the physician selected by Young Life to secure or administer emergency medical treatment, including hospitalization and any other emergency medical procedures which may be needed for the person named herein. I authorize the physician or dentist to call in any necessary consultants in his/her discretion. It is understood that this consent is given in advance of any specific diagnosis or treatment being required, and is given to encourage those persons who have temporary custody of the minor, and said physician or dentist to exercise their best judgment as to the requirements of such diagnosis or medical, dental or surgical treatment. In addition, I authorize camper to carry emergency medications and use as directed.

Signature of parent or guardian or adult camper/staffer _____ Date _____

I agree to remain fully liable and responsible for the payment of any such hospital, doctor, ambulance, dental or medical fees with the exception of the Accident Coverage as set out herein. I further agree that in giving this permission and authorization, Young Life does not assume any responsibility or liability for the payment of such hospital, doctor, ambulance, dental or other medical fees which may be incurred. The completed forms may be photocopied and maintained by authorized personnel for trips out of camp.

Signature of parent or guardian or adult camper/staffer _____ Date _____

Camper may carry emergency medications and use as prescribed.

Signature of parent or guardian or adult camper/staffer: _____ Date _____

AUTHORIZATION FOR OVER-THE-COUNTER MEDICATIONS

In the event your child experiences minor discomforts during camp, we would like the opportunity to make your child as comfortable as possible. Therefore, below is a list of over-the-counter medications that can be administered by Young Life personnel with your authorization. These medications are approved by the Young Life Medical Director using the recommended doses from the manufacturers. This service is provided to alleviate your child's minor discomforts and avoid being sent home early from camp. The below approved medications are intended for occasional use only. If your child requires any medication on a regular basis, you must have a medication authorization form completed by your health care provider and supply the medications. I consent to the administration of the below indicated over-the-counter medications which will be available, at no charge, for all campers. Please make available the following medications to my child (check all that apply). If they are NOT checked they WILL NOT be given to the camper.

Acetaminophen (generic for Tylenol)
 Antibiotic Cream (for minor cuts/scrapes)
 Calamine Lotion (for itching)
 Ibuprofen (generic for Advil & Motrin)
 Loratadine (generic for Claritin)
 Diphenhydramine (generic for Benadryl)
 I do not want over-the-counter medications given to my child

**I have received, reviewed, and agree to the release of my health information as outlined in Young Life's "Notice of Privacy Practices" handout. Additional copies available at www.younglife.org.*

Signature of parent or guardian or adult camper/staffer _____ Date _____

ACKNOWLEDGEMENT OF INHERENT RISK

I ACKNOWLEDGE AND UNDERSTAND THERE ARE INHERENT RISKS ASSOCIATED WITH MANY CAMP ACTIVITIES. I WILL ASSUME THE RISK ASSOCIATED THEREWITH, WHETHER KNOWN OR UNKNOWN TO ME AT THIS TIME. I RECOGNIZE THAT MY ATTENDANCE AT A YOUNG LIFE CAMP IS A PRIVILEGE AND AS A CONSIDERATION FOR THIS PRIVILEGE, I RELEASE YOUNG LIFE AND NORTHBAY, LLC, INCLUDING ITS EMPLOYEES, AGENTS AND TRUSTEES, FROM RESPONSIBILITY FOR MY ACCIDENTAL PHYSICAL INJURY, INCLUDING DEATH OR ILLNESS, AND LOSS OF PERSONAL PROPERTY WHILE AT CAMP OR DURING YOUNG LIFE SPONSORED TRAVEL TO AND FROM CAMP. THIS RELEASE IS ALSO INTENDED TO INCLUDE ALL CLAIMS MADE BY MY FAMILY, ESTATE, HEIRS, PERSONAL REPRESENTATIVE OR ASSIGNS. I GRANT PERMISSION FOR MY CHILD TO PARTICIPATE IN ALL SPECIAL TRIPS OFF THE CAMP PROPERTY WITH PROPER STAFF SUPERVISION.

Signature of parent or guardian or adult camper/staffer _____ Date _____

UNDER COLORADO LAW, AN EQUINE PROFESSIONAL IS NOT LIABLE FOR ANY INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES, PURSUANT TO SECTION 13-21-119, COLORADO REVISED STATUTES.

UNDER ARIZONA LAW, A SIGNED RELEASE ACKNOWLEDGES THAT THE PERSON IS AWARE OF THE INHERENT RISKS ASSOCIATED WITH EQUINE ACTIVITIES, IS WILLING AND ABLE TO ACCEPT FULL RESPONSIBILITIES FOR HIS OWN SAFETY AND WELFARE AND RELEASES THE EQUINE OWNER OR AGENT FROM LIABILITY UNLESS THE EQUINE OWNER OR AGENT IS GROSSLY NEGLIGENT OR COMMITS WILLFUL, WANTON OR INTENTIONAL ACTS OR OMISSIONS.

WAIVER AND RELEASE

IF I AM UNDER AGE 18, MY PARENT OR GUARDIAN, BY SIGNING BELOW, ALSO CONSENTS TO MY RELEASE AND HE OR SHE AGREES THAT THIS RELEASE SHALL BE BINDING UPON HIM OR HER AS MY PARENT OR GUARDIAN AS TO ME AND MY ESTATE, HEIRS, PERSONAL REPRESENTATIVES AND ASSIGNS. MY PARENT OR GUARDIAN ALSO PROMISES, BY SIGNING BELOW TO DEFEND, INDEMNIFY AND HOLD YOUNG LIFE AND NORTHBAY, LLC, HARMLESS FROM ANY CLAIM ASSERTED BY ME AGAINST YOUNG LIFE AND NORTHBAY, LLC, INCLUDING ITS TRUSTEES, EMPLOYEES AND AGENTS, IF I SHOULD REPUDIATE THIS RELEASE AFTER OBTAINING ADULTHOOD. I AGREE THAT ANY LAWSUIT BROUGHT AGAINST ANY RELEASED PARTY SHALL BE BROUGHT SOLELY IN THE CIRCUIT COURT OF CECIL COUNTY, MARYLAND.

PHOTO RELEASE

I HEREBY GRANT PERMISSION TO YOUNG LIFE THE RIGHT TO USE, REPRODUCE, AND/OR DISTRIBUTE PHOTOGRAPHS, FILMS, VIDEOTAPES, AND SOUND RECORDINGS OF MY CHILD, WITHOUT COMPENSATION OR APPROVAL RIGHTS, FOR USE IN MATERIALS CREATED FOR PURPOSES OF PROMOTING THE ACTIVITIES OF YOUNG LIFE.

Signature of parent or guardian or adult camper/staffer _____ Date _____

I also understand and agree to abide with the restrictions placed on my camp activities as listed herein.

Signature of minor or adult camper/staffer _____ Date _____
(If camper is emancipated, proof must be provided prior to camp.)

Printed name of minor or adult camper/staffer _____ Date _____