



CAMPING HEALTH, CONSENT AND RELEASE FORM FOR INFANTS/TODDLERS

FOR AREA DIRECTORS	
Area #	_____
Area Name	_____
Trip Leader/Area Dir.	_____
Camp Dates	_____

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. Proof of physical examination (within past 12 months), verified by Physician's signature, is recommended for all camps (physician's signature required for camps in CO or MN). Physician's release required for all infants from 6-12 weeks on camp date.
4. Infants younger than 6 weeks on camp date may not attend any camp.
5. Infants younger than 12 weeks may not attend Washington Family Ranch, Malibu Club, Beyond Malibu, Wilderness Ranch, or remote camps.

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

Name _____ Birthdate _____ Sex _____ Age _____
Last First Middle Initial

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

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

Business Address _____ Phone (____) _____

Second Parent or Guardian Emergency Contact _____

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

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

If not available in an emergency, notify: Name _____

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

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.

PROVIDE ►
Insurance Information

◀ PROVIDE
Insurance Information

Health Care Recommendations: A physician's signed verification is recommended to be on file at the time of registration in order for an infant/toddler to attend any camp (physician's verification required for camps in CO and MN). Physician's release required for all infants from 6-12 weeks on camp date. Infants younger than 6 weeks on camp date may not attend any camp. Infants younger than 12 weeks on camp date may not attend remote camps listed above.

I have examined the applicant within the past 12 months. Date examined _____
 In my opinion, the applicant's condition does does not preclude her participation in an active camp program.

Licensed Physician's Signature _____ Date _____ Print Name _____

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

Date of form completion _____ *By _____ (*Initial if completed by nurse or physician's assistant)

DOCTOR ►
SIGN IF NEEDED

◀ DOCTOR
SIGN IF NEEDED

Height _____ Weight _____ Blood Pressure _____

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

Current treatment (include current medications) _____

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

Recommendations and Restrictions While at Camp

Any treatment to be continued at camp _____

Any medication to be administered at camp (specific dosages) _____

Any medically-prescribed meal plan or dietary restrictions _____

Additional health information/Activities to be limited _____

IMMUNIZATIONS	HEALTH HISTORY	
* If completing this form for a camper/work crew attending a camp in the state of Colorado (Crooked Creek Ranch, Frontier Ranch, RMR Backcountry, Wilderness Ranch) and the attendee has been immunized, a state certificate of immunization must be attached to this form and presented at camp. Alternatively, a letter of exemption for religious reasons must be attached.		
<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: _____		
ALLERGIES and DIETARY RESTRICTIONS (List any food, drug, plant, insect, or other allergies) Note – This information will be shared with appropriate 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 <input type="checkbox"/> Peanut Allergy <input type="checkbox"/> Soy Allergy <input type="checkbox"/> No Pork – Describe below: <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		

Operations or serious injuries (dates) _____

Chronic or recurring illness or medical condition _____

Current medications (provide instructions) _____

Other diseases _____

Name and phone of family physician _____

Name and phone of dentist/orthodontist _____

Special health and behavioral considerations _____

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.

SIGN ► Signature of parent or guardian or adult camper/staffer _____ **◄ SIGN**

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.

SIGN ► Signature of parent or guardian or adult camper/staffer _____ **◄ SIGN**

**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.*

SIGN ► Signature of parent or guardian or adult camper/staffer _____ **◄ SIGN**

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, 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.

SIGN ► Signature of parent or guardian or adult camper/staffer _____ **◄ SIGN**

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 HARMLESS FROM ANY CLAIM ASSERTED BY ME AGAINST YOUNG LIFE, INCLUDING ITS TRUSTEES, EMPLOYEES AND AGENTS, IF I SHOULD REPUDIATE THIS RELEASE AFTER OBTAINING ADULTHOOD.

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 _____

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

SIGN ► Signature of minor or adult camper/staffer _____ Date _____ **◄ SIGN**

(If camper is emancipated, proof must be provided prior to camp.)