

## YOUNG LIFE CAMPING HEALTH, CONSENT AND RELEASE FORM

Information in this document is protected by HIPAA privacy laws and should be handled accordingly.

This form is only good for travel and attendance at this specific camp. 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. It is important that we have the

following information, which will be shared with appropriate staff, to keep you or your child safe at camp and in the event of an accident or illness. However, in the event of an accident or illness, it is important that we have the following information:

- Medical history & medical insurance information
- 2. Proof of physical examination, verified by physician's signature, required for specific guests attending Beyond Malibu or camps located in CO or MN (Castaway, Crooked Creek, Frontier Ranch, Rocky Creek Ranch, or Wilderness Ranch). See Health Care Recommendations section below for additional information.
- 3. Pregnant and Post-Delivery Teens: Pregnant teens 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 are not allowed to attend camp. Pregnant teens over 30 weeks may not attend Washington Family Ranch, Beyond Malibu, Wilderness Ranch, or remote camps.*
- 4. A physician's release is required for all infants 6-12 weeks on camp date and for infants attending any CO or MN camps. Infants younger than 6 weeks on camp date may not attend any camp. Infants younger than 12 weeks may not attend Washington Family Ranch, Malibu Club, Beyond Malibu, Wilderness Ranch, or remote camps.

Na	ame			Birthdate	☐ Male Gender ☐ Female Age	
					Cell Phone ()	
						_
	ome AddressStreet Address	City	State/Province	Zip	Home Phone ()	_
W	/ork AddressStreet Address	City	State/Province	Zip	Work Phone ()	_
	econd Parent/Guardian		Email		Cell Phone ()	_
Н	ome Address				Home Phone()	_
W	Street Address  /ork Address	City	State/Province	Zip	Work Phone ()	
	Street Address not available in an emergency, notify:	City	State/Province	Zip	Cell Phone ()	
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Н	ome Address	City	State/Province	Zip	Home Phone ()	_
Na	ame of School Camper Attends (if app	licable)				
REQUIRED	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 \$20,0 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-pay. Life's policy does not cover camper illnesses or pre-existing conditions. If you have questions, please contact Young Life's Risk Management at (719) 867-3600.  For all camps and travel outside of the USA, you are responsible to confirm that your medical insurance provides coverage for accidents/or illness outside the USA and/or you have purchas international travel medical insurance for yourself or your child. You also acknowledge and agree that you are personally responsible for any and all medical costs including all emergency transportation costs that are not covered by your personal medical health insurance.  Policy Number					REQUIRED
	Insurance company address/Web address					
	DOCTOR INFORMATION: Name of family					$\neg$
	Name of dentist	Phone ()	Orthodontist		Phone ()	
	18 attending camps located in CO; those at given birth within 12 weeks of the camp da 1. Has the applicant been diagnosed with a etc. that could limit participation at <b>camps</b>	ttending camps located in MN; ate. <b>A parent or adult applica</b> a medical condition or disease	; those attending Beyo nts must complete the of the blood, respirato	nd Malibu; those at e section below if the	ection for the following individuals: those under the age of tending <b>any</b> Young Life camp who are pregnant or have the <b>above conditions do not apply.</b> ther system, such as sickle cell disease, COPD/emphysema	
POSSIBLE PHYSICIAN SIGN	2. Does the applicant have any additional elevation?  Yes  No If yes, please explain the condition at a surface and the applicant is authorized to carry an PHYSICIAN'S SIGNATURE: (CO, MN, Beyon  I have examined the applicant within Physician Signature Y	nd expected treatments: al medical conditions, includir nd expected treatments: inhaler, epi pen and other eme d Malibu, pregnant/post-deliv	ng those above in #1 ergency medications w erry teens/infants 6-12 Date examined	which could limit price with them at all time weeks). Must be o	varticipation in an active camp program <b>regardless of t</b>	L
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FOR AREA DIRECTORS

☐ Camper ☐ Leader ☐ Assigned Team

☐ Summer Staff ☐ Work Crew ☐ Adult Guest

Area # \_\_\_\_\_ Area Name \_\_\_\_\_ Trip Leader/Area Dir

Camp Dates

	IRABAH IRUZATIONIC			1
	* If completing this form for an infant/toddler, camper or work crew attending a camp in the state of			ı
	Colorado (Crooked Creek Ranch, Frontier Ranch, Rocky Creek Ranch, RMR Backcountry,	HFAL	TH HISTORY	ı
	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	IIEAL		ı
	must be attached.			
	☐ Check and date any immunizations the applicant has received, or	Check if applicant has:	Has applicant had (include date):	
	☐ Applicant has not been immunized for:	☐ Asthma	☐ Chicken Pox	
	☐ medical ☐ personal ☐ or religious reasons.	☐ Bleeding/Clotting Disorder☐ Convulsions in last 60 days	☐ Measles	
	☐ DTaP (Diphtheria, Tetanus, & Pertussis) Date:	☐ Diabetes	☐ German Measles	
	☐ TD (Tetanus and Diphtheria) Date:	☐ Epilepsy/Seizures☐ Frequent Ear Infections	Mumps	
	MMR (Measles, Mumps, Rubella) Date:	☐ Heart Defect/Disease	☐ Hepatitis A	
	□ Polio (OPV or IPV)  Date:	☐ Hypertension	☐ Hepatitis B ☐ Hepatitis C	
	☐ Hepatitis B Date:  ☐ Varicella (Chicken Pox) Date:	☐ Sickle Cell☐ Neurological Condition	☐ Mononucleosis	
	□ Varicella (Chicken Pox) □ HIB (Haemophilus influenza B) Date: □ Date:		Due Date:	
	Other Date:			İ
ŀ			Delivery Date:	i
	ALLERGIES and DIETARY RESTRICTIONS (List any food, drug, plant, insect, or o			
	□ None □ Bees □ Dairy Intolerance □ Amor	9 ,	orugs, insects, plants, food, etc.) OR Dietary	İ
	6,	y Intolerance	e below.	İ
	☐ Celiac Disease ☐ Gluten Intolerance ☐ Milk Allergy ☐ Vege	•		İ
	□ Vegan □ Penicillin □ No Pork □ Sulfa			İ
	PROTECTIVE CUSTODY ARRANGEMENTS			ł
	Is there a court order in place that lists certain persons who are or are not authorize	ed to pick up your child from camp? 🗖	YES □ NO	1
	If yes, the following people are allowed to pick the camper listed from camp			İ
	If yes, the following people are NOT allowed to pick the camper listed up from ca			İ
NÞ	Signature of parent/guardian: X		Date	SIG
	AUTHORIZATION FOR TREATMENT This health history is correct to the best of my knowledge.		-	- Oil
	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 fo selected by Young Life to secure or administer emergency medical treatment, including medical transport			
	be needed for the person named herein. I authorize the medical provider or dentist to call in any necess	sary consultants in his/her discretion. It is unders	stood that this consent is given in advance of any	i
	specific diagnosis or treatment being required, and is given to encourage those persons who have tempt to the requirements of such diagnosis or medical, dental or surgical treatment. In addition, I authorize ca			_
۸Þ	Parent/Guardian/Adult Applicant Signature: X		Date	SIG
	I agree to remain fully liable and responsible for the payment of any such hospital, doctor, medical trar further agree that in giving this permission and authorization, Young Life does not assume any responsible.			-
		nsibility of liability for the payment of such nost	oital, doctor, medical transportation, dental or other 📕	1
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