

Print Participant / Chaperone Name & Organization / School / Group:



JOY OUTDOOR EDUCATION CENTER

MEDICAL FORM & ACKNOWLEDGMENT OF RISK and RELEASE (printed on Back)

INSTRUCTIONS: Please read and complete this form carefully. PLEASE PRINT

PARTICIPANT'S LAST NAME: _____ FIRST: _____ Age: _____
 Circle One: Male / Female Circle One: Chaperone / Participant Participant's Birth Date: / / Zip: _____
 Street Address: _____ City _____ State _____
 Phone () _____

Primary Contact: _____ Relationship: (Parent / Guardian / Spouse / Other): _____
 Primary Contact #'s: Home: () _____ Work: () _____ Other: () _____

IF PRIMARY CONTACT IS NOT AVAILABLE - IN AN EMERGENCY NOTIFY: (List 2 contacts at 2 different addresses)

1. Name: _____ Relationship: _____ 2. Name: _____ Relationship: _____
 Address: _____ Address _____
 Home # () _____ Work # () _____ Home # () _____ Work # () _____

PHYSICIAN & INSURANCE INFORMATION

Medical/Hospital Plan: _____ Policy or Group #: _____
 Policyholders First & Last Name: _____ Employer: _____
 Primary Physician's Name: _____ Phone: () _____
 Family Dentist's Name: _____ Phone: () _____

MEDICATIONS

Prescribed Medicine Name / Reason
 1. _____ Immunizations: DPT Date _____ Tetanus Date _____
 2. _____ Have you had Chicken Pox? Circle: Yes No
 List any dietary restrictions: _____ List any activity restrictions: _____
 List anything else, which would help us, better serve you: _____

MEDICAL CONDITIONS

- Asthma (Does participant carry an inhaler?) _____
- Broken Bones
- Diabetes
- Ear Infections
- Headaches
- Heart Disease
- High Blood Pressure
- Infectious Hepatitis
- Psychiatric Care
- Pregnancy
- Fainting
- Convulsions / Seizures / Epilepsy Date of last Seizure: / /

ALLERGIES: Check all that apply

- Hay Fever
 - Insect Stings
 - Poison Ivy, other plants: _____
 - Peanuts, other foods: _____
 - Penicillin, Other drugs: _____
 - Latex
- Describe Allergic Reaction: _____

Does participant carry an Epi-pen? _____
 (If yes, please send Epi-pen with participant and ensure s/he knows how to use it safely.)

Please describe management of the above conditions / allergies: _____

(Signatures Required on next Page!)

Describe and give dates of any hospitalizations, serious injuries or recurring illness: _____



**This form should be printed on the back of the Medical Form! Each participant and/or their parent must sign this form before the program begins. Without all appropriate signatures, the individual may not be permitted to participate in the program.*

ACKNOWLEDGEMENT OF RISK AND RELEASE

- I understand that my participation in programs offered by Joy Outdoor Education Center are based on a “Challenge by Choice” philosophy. I recognize that the program is designed to use experiential, engaging, teaching techniques, but that my participation is purely voluntary, and I elect to participate in spite of the risks.
- I am aware that experiential, outdoor pursuits such as living history reenactments, climbing, hiking, high ropes courses, ground initiatives, and other activities at Joy Outdoor Education Center, for which I and / or my child have enrolled, entails certain risks.
- I understand that completing and signing the Center’s Confidential Medical Information Form is a prerequisite to participate in this program. The information my child or I have provided is a complete and accurate statement of the physical and psychological factors, which may affect participation in the program.
- Therefore, for myself / my child, I expressly, knowingly and voluntarily assume all risks involved in my participation, and do hereby release Joy Outdoor Education Center and its members, trustees, officers, employees, independent contractors and agents from any and all liability, damages, costs and expenses arising out of or relating to bodily or psychological injury, loss of life or personal property that may occur as a result of participating in this program.
- I have read and understand and accept the terms and conditions stated herein and acknowledge that this agreement shall be effective and binding upon the parties during the entire period of participation in the said program.
- The health history is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted.

Authorization for treatment: I hereby give permission to the medical personnel selected by the visiting organization to arrange necessary related transportation for this participant and assist with prescription or over-the-counter medication if needed. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the visiting school or organization or Joy Outdoor Education Center to secure and administer treatment, including hospitalization, for the person named above.

NOTE: *This participant shall not be permitted to participate in the following activities:

REQUIRED: Signature of participant

Date

REQUIRED: Signature of Parent/Legal Guardian (If participant is under 18)

Date

Media Release: I give my consent for myself or my child to be photographed or videotaped for general camp use, Website, and/or agency publicity.

REQUIRED: Signature of Parent/Legal Guardian (If participant is under 18)

Date