

JOY OUTDOOR EDUCATION CENTER**MEDICAL FORM & ACKNOWLEDGMENT OF RISK and RELEASE**

INSTRUCTIONS: Please read and complete this form carefully. EACH PARTICIPANT AND / OR THEIR PARENT MUST SIGN THIS ACKNOWLEDGMENT OF RISK FORM BEFORE the program begins. Without all appropriate signatures, the individual may not be permitted to participate in the program.

Participant's Name: Last _____ First _____ Circle One: Male Female
Date of Birth: _____
Address: Street _____ City _____ State _____ Zip _____ Phone (____) _____
Primary Contact (Parent/Guardian/Spouse/Other): _____ Relationship _____
Primary Contact Phone #'s: Home: _____ Work: _____ Cell/Beeper/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 Phone (____) _____ Work Phone (____) _____ Home Phone (____) _____ Work Phone (____) _____

PHYSICIAN & INSURANCE INFORMATION

Family Physician's Name _____ Phone _____ Family Dentist's Name _____ Phone _____
Medical/Hospital Plan: _____ Policyholders First & Last Name _____
Health Insurance Company/Carrier _____ Policy or Group # _____

MEDICAL CONDITIONS

- Ear Infections
 Asthma
Does this participant carry an inhaler? ____
 Diabetes
 Headaches
 Infectious Hepatitis
 High Blood Pressure
 Psychiatric Care
 Pregnancy
 Heart Disease
 Fainting
 Convulsions/Seizures/Epilepsy
Date of last Seizure ____

ALLERGIES:

- Hay Fever
 Ivy Poisoning, etc.
 Penicillin
 Other drugs(please specify): _____
 Insect Stings
What type of reaction does this participant have to stings?

Does this participant use an epi-pen for stings? ____
List any other allergies (food, plants, etc.):

MEDICATIONS

Prescribed Medicine Name/Reason
1. _____ / _____
2. _____ / _____

Immunizations: DPT Date ____ Tetanus Date ____

Have you had Chicken Pox? Circle Yes No

In case of pain and primary contact cannot be reached, give this participant: Acetymetiphen (Tylenol) ____
Ibuprofen (Advil) ____ Nothing ____ Other (List) _____

List any diet restrictions: _____

List any activity restrictions: _____

List anything else that would help us better serve you:

Please describe management of the above conditions / allergies:

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

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 and 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 organization or Camp Joy to secure and administer treatment, including hospitalization, for the person named above.
- I give my consent for myself or my child to be photographed or videotaped for general camp, website, and/or agency publicity.

REQUIRED: Signature of participant _____

Date _____

REQUIRED: Signature of Parent (If participant is under 18) _____

Date _____

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