Cedar Springs Camp Lost Creek - MINOR 2019

WAIVER AND RELEASE FROM LIABILITY

(TO BE COMPLETED BY PARTICIPANT)

This agreement is made this _____day of _____, 2019 between
Cedar Springs Camp Lost Creek and_____ ("Participant")

1. **Subject.** Participant recognizes and expressly agrees that participating in any adventure, sport or activity associated with the out-of-doors is an inherently dangerous activity. Further, Participant recognizes that certain safety precautions must be followed, yet even strict adherence to those procedures does not guarantee nor does Cedar Springs Camp Lost Creek guarantee Participant's safety.

2. **Waiver and Release from Liability.** Participant understands that Cedar Springs Camp Lost Creek assumes no responsibility for injuries or illnesses that Participant may sustain, a) as a result of Participant's physical condition, b) resulting from Participant's participation in the activity, c) as a result of another participant's or third person's actions, or d) as a result of participant's use of Cedar Springs Camp Lost Creek facilities, field, and/or equipment in connection with this activity. The Participant releases and agrees to hold harmless, defend and indemnify Cedar Springs Camp Lost Creek and it directors, officers, employees and agents from and against any and all claims for personal injury (including loss of life) and all other losses or damages (except those caused entirely by the gross negligence or intentional conduct of Cedar Springs Camp Lost Creek) that the Participant may suffer as a result of his or her participation and /or enrollment in Cedar Springs Camp Lost Creek activities.

3. **Medical Consent.** Participant grants permission to Cedar Springs Camp Lost Creek and its employees and agents to take the Participant to a licensed physician for medical treatment, emergency surgery, or hospitalization if Participant becomes ill, sustains an injury, or otherwise requires medical treatment or attention and Cedar Springs Camp Lost Creek is unable to contact the Emergency Contact listed by Participant. The Participant gives consent to any licensed physician to administer drugs or medicine or to perform such medical procedures as that physician determines necessary for the relief of pain and to preserve the Participant's life or health. Participant further authorizes Cedar Springs Camp Lost Creek to give first aid, CPR or other treatment by a qualified staff member to Participant.

4. **Property Loss**. Participant understands and agrees that Cedar Springs Camp Lost Creek is not responsible for personal property that is lost, damaged, or stolen in connection with this activity.

5. **Binding Effect.** This Agreement shall be binding upon Participant, his or her heirs, estate, successors, and legal representatives.

6. **Entire Agreement.** This Agreement represents the entire agreement between the parties. This Agreement shall not be modified or amended except by an agreement in writing signed by both parties.

7. **Acceptance.** If any portions of this waiver and release are held to be invalid, Participant agrees the remaining terms shall continue to be in full legal force and effect. Participant understands and agrees that this Waiver and Release is binding upon me and my heirs, estates and legal representatives.

Photo Release: I grant Cedar Springs Camp Lost Creek the absolute right to copyright, re-use, publish and republish by any medium, including electronically, any photos of my child or in which they may be included, that may be taken while participating in Cedar Springs Camp Lost Creek activities. Yes: _____ No: _____

PLEASE READ CAREFULLY. THIS DOCUMENT CONTAINS A RELEASE AND WAIVER OF LIABILITY.

I have read and voluntarily signed this Waiver and Release of Liability.

Parent Signature Date

Camp Calvin 2019

Health History and Medical Authorization Form

Child's Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Church: _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian 1: _____ Address (if different than child's): _____

Phone #1: _____ Phone #2: _____ Email: _____

Parent/Guardian 2: _____ Address (if different than child's): _____

Phone #1: _____ Phone #2: _____ Email: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Phone #1: _____ Phone #2: _____

Name: _____ Relationship: _____ Phone #1: _____ Phone #2: _____

HEALTH INFORMATION

Health Conditions: _____

_____

_____

_____

_____

Explain any specific needs or accommodations required: _____

_____

Explain any known behavioral and/or emotional problems: _____

_____

Explain any operations or serious injuries: _____

_____

Explain any disabilities or chronic or recurring illnesses: _____

_____

Explain any activities that are discouraged or limited by you or your child's physician: _____

_____

Explain any dietary modifications: _____

_____

IMMUNIZATION HISTORY

Are all immunizations current? ☐ Yes ☐ No Date of last DTP or DT (Tetanus): _____

MEDICATION INFORMATION

Are any prescription medications being taken? ☐ Yes ☐ No Are any of the following used? ☐ Inhaler ☐ EpiPen

Name of Medication	Reason for Medication	Dose	Frequency

My child may be given (per label instructions): ☐Benadryl ☐Ibuprofen ☐Neosporin ☐Tylenol ☐None

AUTHORIZATION FOR HEALTH CARE

This health history is correct so far as I know. The person herein described has permission to engage in all activities except as noted. I hereby give permission to the Camp Nurse or First-Aider to provide routine health care and witness prescribed medications. I consent for my child to receive such medical treatment and/or surgical procedures as are deemed necessary in the event of an emergency. Should a medical emergency arise during my child's participation in a Camp Calvin activity, I understand that reasonable efforts will be made to contact me or my designated alternate at the phone numbers I have given. If it is believed my child's life or health may be adversely affected by the delay that an attempt to contact me or my designated alternate would cause, I consent to the administration of medical treatment and/or surgical procedure deemed necessary by the medical doctor and/or medical facility and the immediate administration of life-sustaining measures deemed necessary under the circumstances. This completed form may be photocopied.

Parent/Guardian Signature:_____ Date: _____