2014 Camper Registration, Health and Release Form

Information on this form is not part of the camper or staff acceptance process, but is gathered to assist in identifying appropriate care needs. This is to be filled in by the camper's parent or guardians and is **mandatory** for each camper. Form must be received prior to camper's attendance. The persons listed here will be contacted to assist in medical/behavioral problem solving if the parent/guardian cannot be reached.
All medications must be in original pharmacy containers with labels.
Ages 9-14 years **The cost of Alphapointe Adventure Camp is $50**

Please fax completed form to 816-237-2065. **Attention: Shelley Baker, OTR/L, (816) 237-2059, sbaker@alphapointe.org**

Youth Name_______________________ **Date of Birth** ____/____/____ **Sex ❑M ❑F** **Age** _____ **Grade in Fall** _____

Address ______________________________ **City** __________________ **State** ______ **Zip** _______

1.) **Primary Adult Contact**

____

Relationship to camper ____________________________________ Custodial Parent/Guardian ❑Yes ❑No

Address _____________________________________ City, State _________________________ Zip _____________

Phone (Day) __________________ Phone (Evening) __________________ Pager/Cellular ___________________

Email address_________________________

2.) **Second Adult Contact**

____

Relationship to camper ____________________________________ Custodial Parent/Guardian ❑Yes ❑No

Phone (Day) __________________ Phone (Evening) __________________ Pager/Cellular ___________________

Email address_________________________

3.) **Teacher for visually impaired**

name____

email ____________________________________ summer phone_______________________________

4.) **Orientation & Mobility instructor**

name____

email__________________________________ summer phone_______________________________

Health History: Check all that apply.

☐Vision problems? ☐ Speech or hearing problems? ☐Have seasonal allergies? ☐Ever had a broken bone?
☐If female, began menses and bringing supplies to camp? ☐Any other disability? ☐Other?

Specific visual diagnosis______________________________ Does your child have low vision?___________________
Please explain any checked boxes:

____

____

Mental, Social and Emotional Health:

❑This camper has no remarkable mental, social or emotional health needs.

This camper has the following concerns:

❑Diagnosed with Attention Deficit/Hyperactivity Disorder (ADD or ADHD)
❑Psychiatric diagnosis such as depression, OCD, panic/anxiety disorder
❑Has an emotional health concern
❑Has a learning challenge (disability)
❑Has seen or is currently seeing a professional for mental/emotional health concerns
❑Had a significant life event that continues to affect the camper's life? (history of abuse, death of a loved one, family change, survived a disaster, others)

Dietary Restrictions: List anything that is not a true allergy, but would be a preference or requirement. -
____
____
____
____

What Have we Forgotten to Ask? Please provide in the space below any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. Attach additional information if needed.

____
____
____
____

I recognize that participation in recreation and instruction activities, even when well supervised and managed, poses a risk to my child, and I agree to assume such risk on behalf of my child. I, the undersigned, herby hold Alphapointe and Camp Fire USA Heartland Program and Innovation Center, its employees and agents harmless from liability for any and all medical and/or accident expenses that my minor child may incur during their involvement in Alphapointe Adventure Camp. This health history is correct so 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 camp to provide routine healthcare; to administer over-the-counter and prescription medications as directed by a parent; to release any records necessary for insurance proposes; and to provide or arrange necessary related transportation for me or my child. In the event I cannot be reached, in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. These forms may be photocopied for trips out of camp.

Signature ____ Date ________________________

Parent/guardian

I understand and agree to follow the restrictions placed on my camp activities.

Signature of minor ____________________

Heartland Presbyterian Center

PARTICIPANT RELEASE OF LIABILITY & HEALTH INFORMATION FORM

Heartland Presbyterian Center (HPC) policy for participation in all programs requires that every participant provide certain health/medical information to the instructors conducting programs, so that they are prepared to respond appropriately if the need arises. This information will be held in confidence. Participants must complete the form (front and back) and return it to HPC prior to participating in any activities.

Please identify the HPC activity in which you will be participating: ❑Challenge Course ❑GPS Course ❑Horseback Riding

Participant Name: ____

Name of Group: ______________________________ Date of Group: ____________

Address:____________________________City/State/Zip:____________________________

Phone: Day: ( ) ____________ Evening: ( ) ____________ Mobile: ( ) ____________

Gender: ❑ Male ❑ Female Date of Birth: ______________________________

Physician Name: ______________________ Phone: ( ) ______________________

Medical Policy: ______________________ Number: ______________________

Emergency Contact Name: ______________________ Relationship: ____________

Phone: Day: ( ) ______________________ Evening: ( ) ______________________

Media Release-
I agree to allow myself (or my child) to have my/his/her picture taken and those pictures to be used in HPC publicity.

Horseback Riding Release (only applicable for Horseback Riding Participants)-
I acknowledge understanding that trail riding involves being in areas that may have natural and man-made hazards which ride management cannot control, identify, modify, or eliminate: that horses can be excitable, difficult to control and unpredictable: and that accidents can happen to anyone at any time. I agree to take full responsibility for myself, my children, and my property and I will hold HPC, ride management personnel and all property owners on whose horse(s) and/or land this ride takes place, blameless and free from liability for any accidents, injury, or loss that might occur due to my participation or my child's participation in this activity.
Under Missouri Law, an equine professional is not liable for an injury to or the death of a participant in equine activities resulting from the inherent risks of equine activities pursuant to the revised Statutes of Missouri.

Challenge Course Release-
Participating in this program may involve bending, twisting, lifting, running, jumping, climbing, increased heart or breath rates and physical contact with others. Unexpected strains or jolts to your body can occur.

Release of Liability
The undersigned understands that each participant must assume the risk of injury that could result from any of these activities. The undersigned releases HPC, its employees, agents, and representatives, officers, and its Board of Directors and invitees from any and all liability, claims or causes of action for loss of or damage to property or any injury to the participant arising from participation in HPC activities. In signing this application, I hereby certify that this information is correct and give permission for the release of medical records in case of illness or accident.

____
Participant's Signature (if at least 18 years old) Date

____
Parent/Guardian's Signature (if participant is under 18 years old or has a guardian) Date

If you have any questions regarding your program, please contact your HPC Facilitator or office.

PARTICIPANT RELEASE OF LIABILITY & HEALTH INFORMATION FORM

Participant Name: ____

❑ YES ❑ NO	**Require an inhaler for Asthma attacks**	If YES, it is your responsibility to make sure that your prescribed inhaler is readily available during the program.
❑ YES ❑ NO ❑ UNKNOWN	**Allergic to bee stings or other insect bites**	If YES, it is your responsibility to make sure that your prescribed medication or shot(s) are readily available during the program.
❑ YES ❑ NO	**Diabetes**	If YES, it is your responsibility to make sure that you have food or prescribed medication readily available during the program.
❑ YES ❑ NO	**History of seizures**	
❑ YES ❑ NO	**Medical Device (hearing aide, prosthetic, bone brace, etc.)**	Please see below & explain:
❑ YES ❑ NO	**Past injuries: ❑ Back ❑ Shoulder ❑ Knee ❑ Neck ❑ Ankle ❑ Other_______________**	Please see below & explain:
❑ YES ❑ NO	**Experienced a heart attack or heart condition**	Please see below & explain:
❑ YES ❑ NO	**Pregnant**	Please see below.
❑ YES ❑ NO	**Smoker**	
❑ YES ❑ NO	**Diagnosed with high blood pressure**	Please see below.

❑ YES ❑ NO **Current Medications: prescribed, over-the-counter, inhaler, or psychiatric**

Medication	Taken for	Side Effects

❑ YES ❑ NO **Allergies: food, medicine, or environmental**

Allergy	Reaction	Medication Required

❑ YES ❑ NO	**Other mental condition that may effect your participation in your event at HPC.**	If YES, please explain:

If you have a history of heart problems or high blood pressure-You are at risk if you participate physically in this program. There is historical evidence that some individuals with pre-existing heart conditions have suffered heart attacks and death after participating in a Challenge Course/Climbing program. Due to the emotional and physical demands inherent to the activities, you may be jeopardizing your health and well being if you choose to fully participate. You should consult your physician prior to attending the program.

If you are pregnant-You and your unborn child are at risk if you participate physically in this program. Unintentional impacts to your abdomen can occur during many of the activities that involve physical contact. If climbing is a part of your program, you will be required to wear a harness that puts pressure on your abdominal area and back. Due to the types of physical demands inherent to the activities, you may be jeopardizing your health and well being, as well as the health and well being of your unborn child, if you choose to fully participate. You should consult your physician prior to attending the program.

If you are recovering from broken bones, dislocated joints, sprains, strains, back or neck injuries-You are risking re-injury if you participate physically in this program. You should consult your physician prior to attending.

If you have an enlarged organ, are a transplant recipient, or have Downs Syndrome–You are risking injury to weakened areas of your body. You should consult your physician prior to attending the program.

HPC recommends that you do not physically participate in activities that you think might put you at risk. If you are concerned, your Facilitator can provide you with a less physical way to stay involved.

If you have any questions regarding your program, please contact your HPC Facilitator or office.