



JOY OUTDOOR EDUCATION CENTER

(dba Camp Joy)

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: _____ **Circle One:** Chaperone / Participant

Circle One: Male / Female **Participant's Birth Date:** ____ / ____ / ____ **Age:** _____ **Email:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone (____):** _____

Primary Contact: _____ **Relationship:** (Parent / Guardian / Spouse / Other): _____

Primary Contact #'s: Home: (____) _____ Work: (____) _____ Cell/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 # (____) _____
Cell # (____) _____	Cell # (____) _____

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 the management of the above conditions/allergies: _____

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

CONFIDENTIAL



Acknowledgment of Risk and Release

Revised 12/14/2011

INSTRUCTIONS: Please read this form carefully. EACH PARTICIPANT 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.

I understand that my participation in programs offered by Joy Outdoor Education Center, LLC (dba Camp Joy) and Joy Outdoor Education Center Foundation, Inc., is 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 (Ex. Underground Railroad), climbing, hiking, high ropes courses, ground initiatives, and other activities at Camp Joy, for which I have enrolled, entail certain risks.

I understand that completing and signing the Center's Confidential Medical Form (attached) is a prerequisite for me or my child's participation in this program. I certify that the information my child or I have provided is complete and accurate.

Therefore, I, for myself and for my heirs, personal representatives, and assigns, and each of them, forever release and fully discharge Joy Outdoor Education Center, LLC and Joy Outdoor Education Center Foundation, Inc., and each of their members, managers, directors, employees, volunteers, agents, officers, predecessors, affiliates, representatives, successors, and assigns, from any and all actions, causes of action, claims, costs, damages, demands, fees, and/or liability of any kind, nature, or descriptions whatsoever, whether known or unknown, arising out of or in any way related, whether directly or indirectly, to participation in any Camp Joy program, including, but not limited to any physical injury, 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 program.

I understand that photography commonly occurs during Camp Joy programs. I consent for myself and/or my child/minor of legal responsibility to be photographed for general Camp Joy use, including program and/or agency printed/internet publicity. Check this box to decline the photo release.

The health history is correct as far as I know, and the named participant has permission to engage in all prescribed program 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 for the visiting organization or Camp Joy to secure and administer treatment, including hospitalization, for the participant named below.

Address: _____

Email Address: _____ Phone: _____

_____/_____/_____
Signature of participant (REQUIRED) Date

_____/_____/_____
If participant is under 18, Date
(Signature of Parent or Guardian is REQUIRED)

(Print Name Please)

NOTE: This participant shall NOT BE PERMITTED to participate in the following activities:

