



CHRIST'S COMMISSION FELLOWSHIP – YOUTH GROUP

380 S Rosemead Blvd, Pasadena CA

PARENTAL PERMISSION AND MEDICAL AUTHORIZATION FORM

Participant Name: _____

Birth date: _____

I give permission for my child (named above) to attend youth camp, Phase 1 scheduled on July 26th to 28th 2013.

Medical Release

I hereby authorize CCF Youth Group leaders, hospitals, licensed medical or dental providers, and their agents and employees to have access to the information contained in this form and to provide all medical or dental care, routine tests, treatment, and necessary transportation advisable for the health and safety of my child. This authorization includes the authority to consent to any x-ray examinations, anesthetic, medical procedure or treatment, and hospital care under the supervision, and upon the advice of or to be rendered by, a physician or surgeon licensed under the Medical Practice Act or dentist licensed under the Dental Practice Act for my child.

Custody Release

I further authorize the CCF Youth Group Leaders to receive physical custody of my child upon completion of any treatment, and I specifically instruct any treating health facility to surrender physical custody of my child to said adult.

Activity Release

I further give permission for my child to participate in all supervised activities except as noted:

Signature of Parent or Legal Guardian

Printed name of Parent or Guardian

Date

EMERGENCY CONTACT INFORMATION

<u>Parent(s)/Guardian(s)</u>		Phone Type (Home, Mobile, etc.)
_____	<u>Phone Numbers</u>	

City _____ State _____ Zip _____		

Parent(s)/Guardian(s) Email address(es)		

Youth Members Email address(es)		

<u>Other Emergency Contact(s)</u>		Phone Type (Home, Mobile, etc.)
_____	<u>Phone Numbers</u>	

Name(s) _____ Relationship to Participant _____		

HEALTH CARE INFORMATION

<u>Physician</u>	<u>Dentist</u>
_____	_____
Name _____	Name _____
_____	_____
Phone _____	Phone _____
_____	_____
Medical Insurance Company _____	Dental Insurance Company _____
_____	_____
Policy/Group Number _____	Policy/Group Number _____
_____	_____
Name of Policy Holder _____	Name of Policy Holder _____

At the back of this page, please list:

1. any allergies to drugs, foods, plants, insects, etc:
2. any prescription medication to be taken by the participant (including what it is taken for, when it is to be taken, dosage information, and any special procedures):
3. any non-prescription (over-the-counter) medication you do NOT want dispensed to your child:
4. any additional information relevant to participating in CCF LA Youth group activities (dietary needs; surgeries or serious injuries; chronic or recurring illness; medical conditions such as epilepsy or diabetes; psychiatric counseling or indications, etc.):



PARTICIPANT REGISTRATION

In order to comply with American Camping Association and state laws we ask for the following Health History/Medical Consent Form to be completed and signed by each person over the age of 18 or the legal parent/guardian attending VT Ranch. Please be aware that VT Ranch does NOT provide medical or hospital insurance coverage.

Name: _____ Age: _____ D.O.B. _____ Gender: _____ Ht: _____ Wt: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Email: _____ Dates of Camp / Program: _____
 Name of Group: _____
 Phone Number: (____) _____ Status: _____ Camper _____ Leader
 Emergency Contact: _____ Relationship to Camper / Participant: _____
 Phone Number: (____) _____

Thank you for selecting VT Ranch for your experience. During your time at camp your photo may be taken which may be used on our website or used in materials to promote VT Ranch. If you rather not have your photo taken while at VT Ranch, please check here: _____

MEDICAL CONSENT FORM / REQUESTED MEDICAL INFORMATION:

VT Ranch requests this information in order to provide appropriate medical care in the event of your injury and/or illness while at camp. VT Ranch is committed to protecting the confidentiality of this information.

Do you carry family medical/hospital insurance? YES NO
 Insurance Carrier: _____
 Name of Responsible Party: _____
 Policy #: _____
 Address: _____ Phone: (____) _____
 Relationship to Camper: _____
 Name of Family Physician: _____ Phone: (____) _____
 Name of Family Dentist: _____ Phone: (____) _____
 Date of last Tetanus Shot: _____ Are all immunizations up to date? YES NO---->If no, please attach explanation.
 Has Camper been recently exposed (within last 3 weeks) to any kind of Communicable Disease? _____
 Please List ALL Allergies: Drug: _____
 Insect/Plant: _____
 Food: _____ Diet Restrictions: _____
 List medications Camper will require while at camp and reason for taking the medicine: _____

GENERAL HEALTH HISTORY:

Circle "Yes" or "No" for each statement. Explain "Yes" answers below.

- Has/does the camper / participant:
- | | |
|---------------------------------------------------------|---------------------------------------------------------------------------|
| 1. Ever been hospitalized? Yes No | 10. Wear glasses, contacts, or protective eyewear?..... Yes No |
| 2. Ever had surgery? Yes No | 11. Had fainting or dizziness? Yes No |
| 3. Have recurrent/chronic illnesses? Yes No | 12. Passed out/had chest pain during exercise? Yes No |
| 4. Had a recent infectious disease? Yes No | 13. Had mononucleosis ("mono") during the past 12 months?... Yes No |
| 5. Had a recent injury? Yes No | 14. Have problems with falling asleep/sleepwalking? Yes No |
| 6. Had asthma/wheezing/shortness of breath?..... Yes No | 15. Ever had back/joint problems?..... Yes No |
| 7. Have diabetes? Yes No | 16. Have any skin problems?..... Yes No |
| 8. Had seizures? Yes No | 17. Traveled outside the country in the past 9 months?..... Yes No |
| 9. Had headaches? Yes No | |

Please explain "Yes" answers in the space on page 2, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

PLEASE TURN OVER



By signing this form I give my informed consent to the First Aid personnel assigned by Forest Home, Inc. who are certified in a minimum of CPR and First Aid by a nationally recognized provider in accordance with ACA standard HW-1 to provide basic First Aid and comfort measures through standardized camp treatment procedures which includes the use of over-the-counter medications. I understand that it is my responsibility to make arrangements for a camper with greater health care needs than the First Aid personnel can provide within their individual certifications, licenses and scopes of practice. I authorize VT Ranch, Valley Trails Summer Camp, AAA Camp's Inc, Woodcrest Preschool Foundation to arrange for or provide any necessary related transportation to the nearest medical facility for urgent or emergency medical treatment if indicated, and I do assume all responsibility for payment for such treatment. I hereby give permission to the physician selected by VT Ranch, Valley Trails Summer Camp, AAA Camp's Inc, Woodcrest Preschool Foundation to secure and administer any and all medical treatment deemed necessary for me, including hospitalization. This completed form may be photocopied for trips away from VT Ranch, Valley Trails Summer Camp, AAA Camp's Inc, Woodcrest Preschool Foundation properties.

I authorize the use of the following generic, over-the-counter medications as directed by the labels provided by the manufacturer: analgesics, decongestants, antihistamines, cough suppressant and/or expectorants, throat lozenges or spray, anti-nausea/diarrhea, epi-pen, antacid, antibiotic ointment, hydrocortisone cream, burn cream, petroleum jelly, chapped skin/lip treatment, antiseptic skin and wound cleansers, ipecac, glucose, laxatives, electrolyte replacement fluids, analgesic balms and gels, with the exception of _____. I authorize VT Ranch, Valley Trails Summer Camp, AAA Camp's Inc, Woodcrest Preschool Foundation to allow myself to participate in any and all activities that may include but are not limited to those outlined in the camp brochure. As a condition of receiving this benefit, I do hereby agree to the following: I understand that my participation in these activities can expose myself to dangers both from known and unanticipated risks.

Acknowledging that such risks exist, I on behalf of myself and any other party who may have the right to assert any rights for or on my behalf, do hereby forever release and discharge, indemnify and hold harmless VT Ranch, Valley Trails Summer Camp, AAA Camp's Inc, Woodcrest Preschool Foundation, its affiliates, officers, directors, agents, employees, insurers, successors in interest, attorneys, or any other person or persons associated with any or all of them who might be liable (the "Released Parties") from and against any and all claims, causes of action, actions, suits, demands, losses, damages, expenses, costs or liability (collectively, "Losses") arising from or in connection with my participation in VT Ranch, Valley Trails Summer Camp, AAA Camp's Inc, Woodcrest Preschool Foundation camp and its activities, including Losses arising from the negligence of any of the Released Parties, whether such Losses arise in connection with bodily injury (including death), property damage or otherwise (collectively, the "Released Claims"). The Released Claims include Losses arising out of any condition of the premises at which the camp activities are held or the conduct of any person in connection with the preparation for, supervision of, or conduct of any activity, whether planned or unplanned. I further understand and acknowledge that I make this release in full accord and satisfaction of and in compromise of any and all Released Claims. I represent and acknowledge that I have read and understand this form and the release granted above and warrant that all statements made herein are true to the best of my knowledge. I have read and understand this entire form and by signing below agree to the terms herein.

Signature _____ Date _____

For Participants UNDER the age of 18 years:

Signature of Parent / Authorized Legal Guardian _____ Date _____

Answers to "YES" Questions

