4-H CAMP PALMER, INC.
CHALLENGE BY CHOICE COURSE

NAME:____ AGE:______ PHONE:___________________

ADDRESS:____

STATEMENT OF UNDERSTANDING/MEDICAL INFORMATION

I am aware in signing this statement for participation in the programs at 4-H Camp Palmer, Inc. that certain activities are physically demanding. Therefore, physical fitness will increase your enjoyment and ability to participate in the activity. If for any reason you question your ability to participate in the activity, please consult with the instructors prior to participation. While it is impossible to foresee all possible dangers, some of the specific hazards which you might encounter while using the High Ropes Course and Team Building Course include: slipping or falling on the trail, bumps, bruises, cuts, insect bites, poison ivy, sprains, fractures, or other injuries. Please note that most activities are conducted in the out-of-doors in all kinds of weather so proper dress (rain gear, warm clothing) are essential to avoid undue exposure to the elements. The instructors of the course will take every reasonable precaution to minimize exposure to known risks, however, as a participant you acknowledge the nature of the activity and the fact that not all the stresses and hazards connected with the activity can be foreseen. You have the personal responsibility to follow the established safety rules and procedures to the extent that you participate in such activities. If at any time you have questions about the activity, you have the responsibility to consult with your instructor. Sponsoring agencies have the responsibility of providing a progression of appropriate activities which lead to the experiences at The Challenge By Choice Course at 4-H Camp Palmer, Inc.

I recognize that there is a significant element of risk in any adventure, sport or activity associated with the outdoors. Knowing the inherent risks, dangers and rigors involved in the activities, I certify that my family and I, including any minor children, are fully capable of participating in the activities.

I assure full responsibility for my family and myself, including any minor children, for bodily injury, death, loss of personal property, and expense thereof, as a result of my family member(s) participating in the Challenge by Choice Course.

X____ ______________________________

SIGNATURE DATE

(parent or legal guardian must sign for all persons under 18 years of age)

NOTE: ALL PARTICIPANTS SHOULD WEAR LONG PANTS (NO SHORTS) AND ATHLETIC SHOES ON THE ROPES COURSE AND THE TEAM BUILDING COURSES.

EMERGENGY MEDICAL INFORMATION

Allergies to foods, drugs, insect bites, dust. Please identify the nature of your reaction ________________________

____

Physical disabilities or conditions which might limit your participation. Please identify them ___________________

____

If you are presently taking medication, please identify the medications ______________________________________

____

~~~~~~

IIN CASE OF EMERGENCY CONTACT:____

____

RELATIONSHIP HOME PHONE WORK PHONE
~~~~~~

EMERGENCY MEDICAL AUTHORIZATION FOR PARTICIPANTS 18 YEARS OF AGE AND UNDER

PARTICIPANT NAME________________________________ GROUP LEADER______________________________

ADDRESS____ TELEPHONE_________________________________

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under 4-H Camp Palmer and sponsoring agency authority, when parents or guardians cannot be reached.

To Grant Consent

In the event reasonable attempts to contact me at ________________________________(phone number) or __________________________(other parent or guardian) at ___________________________(phone number) have been unsuccessful, I hereby give my consent for : (1) The administration of any treatment deemed necessary by Dr. ________________________________(preferred physician) at ________________________(phone number) or Dr. ________________________________(preferred dentist) at _______________________(phone number) or in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and (2) The transfer of the child to ________________________________(preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medication being taken, and any physical impairments to which a physician should be alerted:

____

____

____

____ ___________________________________

SIGNATURE (parent or guardian of participants 18 and under) DATE

ADDRESS____

Number & Street City State Zip

FOR MORE INFORMATION: (419) 237-2247