



MEDICAL FORM AND LIABILITY RELEASE

Rev. 04/08/2016

Guest Group Name: SOUTH BAY COMMUNITY CHURCH

Event Dates: 1/5/18 to 1/7/18

Participant Information (Please PRINT in ink)

Name: _____ Age: _____ Gender: M / F
First Middle Last

Address: _____ Height: _____ Weight: _____

City: _____ State: _____ Zip: _____ Date of Birth: ____/____/____

E-mail Address: _____ Phone: () _____

Check here if you do not wish to receive updates from The Oaks:

Emergency Contacts (Parent or Legal Guardian if Participant is under 18)

Name: _____ Relationship: _____ Work phone: () _____ Home phone: () _____

Alternate Contact: _____ Work phone: () _____ Home phone: () _____

Primary Care Physician: _____ Medical Office Phone: () _____

Insurance Carrier: _____ Policy Number: _____

Present Health

ALLERGIES

Bee or Insect Sting Allergies: Yes No Treatment for Past Stings: Benadryl Epi-pen Drug Allergies: (list) _____

Food Allergies: (list) _____ Other Allergies: (list) _____

MEDICATIONS:

Important! All Medications MUST be brought in the original container with doctor's instructions.

Activity Restrictions: _____ Physical Handicaps: _____

Date of Last Known Tetanus Shot (DPT): ____/____/____ Date of Last Physical Exam: ____/____/____ All Immunizations up to Date: Yes No
Month / Year Month / Year

Limiting fears: _____ Dietary Restrictions: _____

Health History

We request that you volunteer any conditions below so we may best serve you and comply with state regulations. Please complete all items and list the year for any that apply.

- | | |
|---|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Fainting or Dizziness |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fractures (broken bones) |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Frequent Ear Infections |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gall Bladder Disorder |
| <input type="checkbox"/> Back Pain or Injury | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Bed-wetting | <input type="checkbox"/> Heat Stroke or Exhaustion |
| <input type="checkbox"/> Bleeding/Clotting Disorder | <input type="checkbox"/> Heart Disease or Defect |
| <input type="checkbox"/> Blood Pressure (high/low) | <input type="checkbox"/> Hepatitis A, B, or C |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hernias |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Joint or Muscle Pain |
| <input type="checkbox"/> Concussion/Head Injury | <input type="checkbox"/> Knee Injury or Trouble |
| <input type="checkbox"/> Corrective Lenses (eyes) | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Cramps, severe | <input type="checkbox"/> Motion Sickness |
| <input type="checkbox"/> Cystitis | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Dental Appliances | <input type="checkbox"/> Skin Conditions or Rashes |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sleepwalking |
| <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Sprains or Strains |
| <input type="checkbox"/> Dislocations | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Tumor or Growth |
| <input type="checkbox"/> Emotional/Behavioral Issue | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Epilepsy or Convulsions | <input type="checkbox"/> Urinary Difficulties |

Details on **all current** conditions noted on the left:

List any other recent injuries, illnesses or disabilities with date of occurrence:

_____ / ____ / ____

_____ / ____ / ____

_____ / ____ / ____

Recent hospitalization or surgeries:
(list the date, reason, hospital name and location)

OFFICE USE ONLY		
	Y	N
Meds.		
Ill/Inj.		
Flu.		
HS Check		



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Participant Name: _____

Medical Authorization and Insurance Coverage

THIS HEALTH INFORMATION IS CORRECT, as far as I know. In the event the emergency contact cannot be reached in an emergency during the program dates noted on this form, I HEREBY GIVE PERMISSION to the physician selected by The Oaks, to hospitalize, to secure proper treatment, to order injection, anesthesia, dental care, and/or surgery for the applicant. I GIVE PERMISSION for The Oaks to provide for the applicant a certified First Aid provider to administer First Aid and over the counter medication as needed for illness or injury as well as any medication noted. I AGREE that photocopies or faxes of this complete form are to be considered legally valid and binding for trips off the camp property. I AGREE to obtain and maintain personal insurance covering the applicant in the program with an appropriate waiver of subrogation rights to reflect the fact that the applicant's personal insurance shall supersede and be used before any insurance coverage that may be provided by World Impact, Inc. In the absence of the aforementioned insurance, I AGREE to pay all costs of rescue and/or medical services as may be incurred by the applicant.

Acknowledgment of Risks and Capabilities

I RECOGNIZE that there is a significant element of risk in any sport or activity associated with the outdoors and trust. THESE RISKS MAY INCLUDE but are not limited to falling trees, rocks or other objects, poisonous plants, reptiles and insects, domesticated and wild animals, crossing steep, uneven and loose terrain, exposure to the elements, lightning strikes, fires, stream crossings, open untreated water, flash floods, landslides, depending on other group members for physical and emotional safety, contact with abrasive or slippery rock, equipment failure or misuse, injury from entanglement with ropes, cables and other equipment, and at times a remote location far from modern medical facilities and rescue assistance. I AM AWARE that certain portions of the program are physically demanding and that the applicant may be asked to walk, run, stretch, climb, push, pull, and perform rigorous and potentially risky or dangerous physical activities which may double their normal resting heart rate. I VOLUNTARILY AGREE to participate in the program. I realize that pre-existing medical conditions could affect the applicant's ability to participate in the program, I FURTHER AGREE to get a qualified medical opinion if the applicant is over 50 years old and/or if I doubt their ability to participate in any given activity. I AGREE to abide by the activity restrictions and to participate only to the extent that my medical, physical, emotional, or other conditions create no undue risk to myself, other participants, or program staff. I FURTHER ACKNOWLEDGE that exposure to these inherent risks, rigors and dangers may result in but is not limited to separation from the group, bruising, bodily injury, emotional trauma, permanent disability including loss of sight and in extreme cases death. Knowing these risks and potential consequences, I CERTIFY that the applicant is fully capable of participating in the program activities which may include but are not limited to hiking, backpacking, bouldering, rock climbing, rappelling, initiative games, low ropes, high ropes, caving, mountain biking, paintball, horseback riding, fishing, swimming, water sports, canoeing, sailing, powered water craft, white water rafting, archery, batting cage use, individual sports including skateboarding, and team sports, except as noted under activity restrictions.

Assumption of Responsibility

I AGREE to assume full responsibility for the applicant's actions and their consequences during their participation in the program, and including without limitation, any injury to the applicant and/or property or any inconvenience resulting there from any other circumstance related to such actions. I, the applicant, AGREE to follow the camp rules as recorded in the Guest Group Handbook and communicated to me verbally by The Oaks staff.

Covenant of Good Faith

I AGREE that The Oaks has the right to refuse any applicant it judges to be incapable of meeting the rigors and requirements of participating in these activities. I AGREE that any decision made by the staff of The Oaks will be binding upon the applicant. The Oaks reserves the right to dismiss any applicant (at their own expense) who through their action or in-action, influences or causes an event which is detrimental to the best interests of themselves or others.

Permission for Participation, Transportation, and Promotion

I GRANT PERMISSION for the applicant to engage in all The Oaks camp activities and to be transported by a World Impact, Inc. staff member who is a legally licensed driver on all activities sponsored by The Oaks, on and off the camp property for the duration of the camping session. I AUTHORIZE use of photos or video taken of the applicant at camp, quotations from evaluations, letters or interviews relating to the program experience for promotion and commercial purposes.

Waiver of Liability

I HEREBY RELEASE and agree to INDEMNIFY, DEFEND AND HOLD HARMLESS World Impact, Inc. its board of directors, officers, directors, employees, guides, agents and volunteers and each and every land owner, municipality and/or governmental agency upon whose property the activity is conducted, from any and all liability, claims, losses, costs, expenses (including without limitation, attorney fees) or demands (except those arising from the gross negligence or willful misconduct of the aforementioned parties) that I, my heirs, executors, trustees, administrators, assignees, distributees, personal or legal representatives and all members of my family, may now have or in the future make against such parties as a result of or related to any injury, loss, death or damage of any kind whatsoever resulting from the applicant's participation in this program or from any driving mishap that may occur during transportation.

Acceptance Signature

I/WE HAVE READ, UNDERSTOOD AND ACCEPTED the terms and conditions stated herein and acknowledge that this agreement shall be effective and binding upon the applicant hereafter.

(Please write in ink)

Participant Signature or Legal Guardian (if under 18): **X** _____ Date: _____

Please Print Name: _____

Please Check One: PARENT GUARDIAN SELF



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