



CAMPING HEALTH, CONSENT AND RELEASE FORM

Information in this document is protected by HIPAA privacy laws and should be handled accordingly.

This form is only good for travel to and from, and attendance at, this specific camp. A new form must be completed for each Young Life Camp experience.

MAKE A COPY FOR YOUR RECORDS. CAMPS MAY NOT FAX OR SEND COPIES TO OTHER CAMPS.

Note to Parent/Guardian/Guest: Young Life wants the camp experience to be a safe and healthy one. However, in the event of an accident or illness, it is important that we have the following information:

1. Medical history
2. Medical insurance information
3. Proof of physical examination, verified by physician's signature, required for ALL guests attending Beyond Malibu or camps located in CO or MN (Castaway, Crooked Creek, Frontier Ranch, Quaker Ridge, RMR, Trail West, or Wilderness Ranch).
4. Pregnant and Post-Delivery Teens: Pregnant teens and teen moms 6 to 12 weeks post-delivery on camp date must have a physician's release. **Teen moms less than 6 weeks post-delivery on camp date may not attend. Pregnant teens over 34 weeks are not allowed to attend camp. Pregnant teens over 30 weeks may not attend Washington Family Ranch, Beyond Malibu, Wilderness Ranch, or remote rental camps.**

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| FOR AREA DIRECTORS | |
| Area # | <u>WA363</u> |
| Area Name | <u>UP & N. Tacoma</u> |
| Trip Leader/Area Dir | _____ |
| School Name | _____ |
| Camp Dates | <u>July 5-9th</u> |
| <input checked="" type="checkbox"/> Camper | <input type="checkbox"/> Leader <input type="checkbox"/> Assigned Team |
| <input type="checkbox"/> Summer Staff | <input type="checkbox"/> Work Crew <input type="checkbox"/> Adult Guest |

Name _____ Birthdate _____ Gender Male Female Age _____

Parent/Guardian/Spouse _____ Email _____ Cell Phone (_____) _____

Home Address _____ Home Phone (_____) _____

Second Parent/Guardian _____ Email _____ Cell Phone (_____) _____

Home Address _____ Home Phone (_____) _____

If not available in an emergency, notify: _____ Cell Phone (_____) _____

Home Address _____ Home Phone (_____) _____

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| ACCIDENT COVERAGE | REQUIRED |
| I understand that my personal insurance will be primary coverage for camper accidents and that Young Life's insurance is secondary up to a maximum of \$20,000 (\$4,000 for dental claims). Exception: If the total claim is less than \$250, Young Life will pay the full amount. On claims above \$250, Young Life will coordinate payments for deductibles and co-pays. Young Life's policy does not cover camper illnesses. If you have questions, please contact Young Life Benefits and Insurance at (719) 381-1950. | |
| <input type="checkbox"/> My insurance company _____ Policy Number _____ Insurance company address _____ | |
| <input type="checkbox"/> Not currently insured – Young Life reserves the right to subrogation if it is later determined that personal medical insurance was in place. | |

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| Health Care Recommendations: This section must be completed by a physician, nurse practitioner, or physician's assistant for all individuals attending Beyond Malibu; all individuals attending camps located in CO or MN; or for a teen attending any Young Life camp who is pregnant or has given birth within 12 weeks of the camp date. Parent or adult applicant must complete this section if these conditions do not apply. | PHYSICIAN SIGN |
| 1. Does applicant have a medical condition such as sickle cell or respiratory or other ailment or condition which would prevent participation at camps with an altitude of 7–14,000 feet? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe condition: _____ | |
| 2. Does the applicant have a medical condition which would prevent participation in an active camp program? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe condition: _____ | |
| 3. The applicant is authorized to carry an inhaler, epi pen and other emergency medications with them at all times? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| PHYSICIAN'S SIGNATURE (CO, MN, Beyond Malibu, pregnant/post-delivery teens) | |
| <input type="checkbox"/> I have examined the applicant within the past 12 months. Date examined _____ Height _____ Weight _____ Blood Pressure _____ | |
| Physician Signature _____ Date _____ Print Name _____ <small>May be signed by Physician, Nurse Practitioner, or Physician's Assistant</small> | |
| Address _____ Phone (_____) _____ | |

The applicant is currently under the care of a physician for the following condition(s) _____

Chronic or recurring illness or medical condition (including behavioral conditions); operations or serious injuries (dates) _____

Explanation of any reported loss of consciousness, convulsion or concussion _____

Any medically-prescribed meal plan or dietary restrictions _____

Any camp activities from which applicant should be excluded _____

List any medication/treatment to be continued at camp (specify dosages) _____

Name of family physician _____ Phone (_____) _____

Name of dentist _____ Phone (_____) _____ Orthodontist _____ Phone (_____) _____

| IMMUNIZATIONS | HEALTH HISTORY | |
|---|---|--|
| <input type="checkbox"/> Check and date any immunizations the applicant has received, or <input type="checkbox"/> Applicant has not been immunized for: <input type="checkbox"/> medical <input type="checkbox"/> personal <input type="checkbox"/> or religious reasons. | Check if applicant has: <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding/Clotting Disorder <input type="checkbox"/> Convulsions in last 60 days <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy <input type="checkbox"/> Frequent Ear Infections <input type="checkbox"/> Heart Defect/Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Sickle Cell | Has applicant had (include date): <input type="checkbox"/> Chicken Pox _____ <input type="checkbox"/> Measles _____ <input type="checkbox"/> German Measles _____ <input type="checkbox"/> Mumps _____ <input type="checkbox"/> Hepatitis A _____ <input type="checkbox"/> Hepatitis B _____ <input type="checkbox"/> Hepatitis C _____ <input type="checkbox"/> Mononucleosis _____ |
| <input type="checkbox"/> DTaP (Diphtheria, Tetanus, & Pertussis) Date: _____ <input type="checkbox"/> TD (Tetanus and Diphtheria) Date: _____ <input type="checkbox"/> MMR (Measles, Mumps, Rubella) Date: _____ <input type="checkbox"/> Polio (OPV or IPV) Date: _____ <input type="checkbox"/> Hepatitis B Date: _____ <input type="checkbox"/> Varicella (Chicken Pox) Date: _____ <input type="checkbox"/> HIB (Haemophilus influenza B) Date: _____ <input type="checkbox"/> Other Date: _____ | <input type="checkbox"/> Currently Pregnant <input type="checkbox"/> Delivered baby in last 12 weeks | Due Date: _____ Delivery Date: _____ |

ALLERGIES (List any food, drug, plant, insect, or other allergies)

PROTECTIVE CUSTODY ARRANGEMENTS

Is there a court order in place that lists certain persons who are or are not authorized to pick up your child from camp? YES NO

If yes, the following people are allowed to pick my child up from camp _____

If yes, the following people are NOT allowed to pick my child up from camp _____

Signature of parent/guardian _____ Date _____

← SIGN

AUTHORIZATION FOR TREATMENT

This health history is correct to the best of my knowledge, and the person herein named has permission to engage in all camp activities except as noted. I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to maintain and/or release any medical records necessary for insurance purposes as outlined under the HIPAA regulations*; and to provide or arrange necessary related transportation for me or my child. In an emergency, I hereby give permission and authorize the physician selected by Young Life to secure or administer emergency medical treatment, including hospitalization and any other emergency medical procedures which may be needed for the person named herein. I authorize the physician or dentist to call in any necessary consultants in his/her discretion. It is understood that this consent is given in advance of any specific diagnosis or treatment being required, and is given to encourage those persons who have temporary custody of the minor, and said physician or dentist to exercise their best judgment as to the requirements of such diagnosis or medical, dental or surgical treatment. In addition, I authorize camper to carry emergency medications and use as directed.

Parent/Guardian/Adult Applicant Signature _____ Date _____

I agree to remain fully liable and responsible for the payment of any such hospital, doctor, ambulance, dental or medical fees with the exception of the Accident Coverage as set out herein. I further agree that in giving this permission and authorization, Young Life does not assume any responsibility or liability for the payment of such hospital, doctor, ambulance, dental or other medical fees which may be incurred. The completed forms may be photocopied and maintained by authorized personnel for trips out of camp.

Parent/Guardian/Adult Applicant Signature _____ Date _____

**I have received, reviewed, and agree to the release of my health information as outlined in Young Life's "Notice of Privacy Practices" handout. Additional copies available at www.younglife.org.*

Parent/Guardian/Adult Applicant Signature _____ Date _____

← SIGN

← SIGN

← SIGN

ACKNOWLEDGEMENT OF INHERENT RISK

I ACKNOWLEDGE AND UNDERSTAND THERE ARE INHERENT RISKS ASSOCIATED WITH MANY CAMP ACTIVITIES. I WILL ASSUME THE RISK ASSOCIATED THEREWITH, WHETHER KNOWN OR UNKNOWN TO ME AT THIS TIME. I RECOGNIZE THAT MY ATTENDANCE AT A YOUNG LIFE CAMP IS A PRIVILEGE AND AS A CONSIDERATION FOR THIS PRIVILEGE, I RELEASE YOUNG LIFE, INCLUDING ITS EMPLOYEES, AGENTS AND TRUSTEES, FROM RESPONSIBILITY FOR MY ACCIDENTAL PHYSICAL INJURY, INCLUDING DEATH OR ILLNESS, AND LOSS OF PERSONAL PROPERTY WHILE AT CAMP OR DURING YOUNG LIFE SPONSORED TRAVEL TO AND FROM CAMP. THIS RELEASE IS ALSO INTENDED TO INCLUDE ALL CLAIMS MADE BY MY FAMILY, ESTATE, HEIRS, PERSONAL REPRESENTATIVE OR ASSIGNS. I GRANT PERMISSION FOR MY CHILD TO PARTICIPATE IN ALL SPECIAL TRIPS OFF THE CAMP PROPERTY WITH PROPER STAFF SUPERVISION.

Parent/Guardian/Adult Applicant Signature _____ Date _____

UNDER **COLORADO** LAW, AN EQUINE PROFESSIONAL IS NOT LIABLE FOR ANY INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES, PURSUANT TO SECTION 13-21-119, COLORADO REVISED STATUTES.

UNDER **ARIZONA** LAW, A SIGNED RELEASE ACKNOWLEDGES THAT THE PERSON IS AWARE OF THE INHERENT RISKS ASSOCIATED WITH EQUINE ACTIVITIES, IS WILLING AND ABLE TO ACCEPT FULL RESPONSIBILITIES FOR HIS OWN SAFETY AND WELFARE AND RELEASES THE EQUINE OWNER OR AGENT FROM LIABILITY UNLESS THE EQUINE OWNER OR AGENT IS GROSSLY NEGLIGENT OR COMMITS WILLFUL, WANTON OR INTENTIONAL ACTS OR OMISSIONS.

WAIVER AND RELEASE

IF I AM UNDER AGE 18, MY PARENT OR GUARDIAN, BY SIGNING BELOW, ALSO CONSENTS TO MY RELEASE AND HE OR SHE AGREES THAT THIS RELEASE SHALL BE BINDING UPON HIM OR HER AS MY PARENT OR GUARDIAN AS TO ME AND MY ESTATE, HEIRS, PERSONAL REPRESENTATIVES AND ASSIGNS. MY PARENT OR GUARDIAN ALSO PROMISES, BY SIGNING BELOW TO DEFEND, INDEMNIFY AND HOLD YOUNG LIFE HARMLESS FROM ANY CLAIM ASSERTED BY ME AGAINST YOUNG LIFE, INCLUDING ITS TRUSTEES, EMPLOYEES AND AGENTS, IF I SHOULD REPUDIATE THIS RELEASE AFTER OBTAINING ADULTHOOD.

PHOTO RELEASE

I HEREBY GRANT PERMISSION TO YOUNG LIFE THE RIGHT TO USE, REPRODUCE, AND/OR DISTRIBUTE PHOTOGRAPHS, FILMS, VIDEOTAPES, AND SOUND RECORDINGS OF MY CHILD, WITHOUT COMPENSATION OR APPROVAL RIGHTS, FOR USE IN MATERIALS CREATED FOR PURPOSES OF PROMOTING THE ACTIVITIES OF YOUNG LIFE.

Parent/Guardian/Adult Applicant Signature _____ Date _____

Applicant understands and agrees to abide with the restrictions placed on his/her camp activities as listed herein. Parent/Guardian may sign for minor, acknowledging their agreement.

Parent/Guardian/Adult Applicant Signature _____ Date _____

(If camper is emancipated, proof must be provided prior to camp.)

← SIGN

← SIGN



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Young Life is committed to protecting your personal health information. Personal health information may include such items as health consent forms, medical history information, etc.... This notice about protecting your health information is required by law. It tells you about your rights and how Young Life uses and discloses your health information.

Your Health Information Rights

You have certain rights regarding the health information Young Life has about you. You have the right to:

- Request a restriction on certain uses and disclosures of your health information; however, Young Life is not required to approve your request.
- Request that Young Life notify you about your health information in a way or at a location that will help you keep your health information confidential.
- Receive a list of disclosures Young Life has made of your health information.
- In writing at any time, withdraw your permission for Young Life to disclose your health information, except for the information that Young Life disclosed before you stopped your permission.
- Ask Young Life to change your health information if you believe it is incorrect or incomplete. Young Life may deny your request and, if so, will give you the reason(s) why the request was denied.
- Receive a paper or electronic copy of this Notice of Privacy Practices upon request.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one of these rights, contact:

The Young Life Benefits Department
Attention: Privacy Official
420 North Cascade Avenue
Colorado Springs, CO 80903
(719) 381-1800

How Young Life May Use or Disclose Your Health Information

The law permits Young Life to use or disclose your health information for the following purposes:

Treatment - Young Life may use and disclose your health information to help you receive medical treatment and services.

Example: Young Life may use your medical history information to ensure that you receive proper medical care, should you become injured.

Payment - Young Life may use and disclose your health information to pay for your medical treatment and services

Example: A claim for healthcare services may be sent to Young Life by your doctor. The claim may contain information that identifies you, your diagnosis, and the treatment or supplies you received.

Health Care Operations - Young Life may use and disclose your health information to internal auditors.

Example: Your health information may be disclosed to the medical staff or quality improvement staff to review the effectiveness of the medical care you received.



Requirements by Law - Young Life may use and disclose your health information when the law requires it.

Example: Young Life may disclose information for the following purposes:

- To reply to proper requests for your health information from a court or other legal agency.
- To report information for public health, such as reporting victims of abuse, neglect or domestic violence, or reporting to the Food and Drug Administration, problems with products or reactions to medications.
- To report information for public safety, such as to prevent the spread of a serious threat to the health or safety of a particular person or the general public.
- To assist law enforcement officials, such as the police, in their law enforcement duties.
- To allow funeral directors, medical examiners or coroners to carry out their lawful duties, such as to complete a death certificate for the state.
- To comply with laws and regulations related to Workers' Compensation.
- To allow other government agencies to provide you with benefits and services.

Health Oversight Activities - Young Life may disclose your health information to government health agencies for health oversight reasons, such as program audits or licensure review.

Research - Young Life may use your health information for approved research purposes, such as for a study to cure a disease.

Special Government Functions – “Special government functions” such as protection of public officials or reporting to various branches of the armed services, may require the use or disclosure of your health information.

Obligations of Young Life

Young Life is required to:

- Maintain the privacy of your protected health information.
- Provide you with this Notice of its legal duties and privacy practices with respect to your health information.
- Obtain your written authorization to use or disclose your health information for reasons other than those listed in this Notice and permitted under law.
- Abide by the terms of this Notice that are currently in effect.
- Notify you if Young Life is unable to agree to a requested restriction on how your information is used or disclosed.
- Allow reasonable requests you may make to notify you about your health information in a way or at a location that will help you keep your health information confidential.

Young Life reserves the right to change its information practices. The new provisions will be effective for all protected health information that The Young Life Benefits Plan maintains. Revised notices will be made available by contacting the administration office of the camp you are attending.

If you have a complaint about this Notice of Privacy Practices, how Young Life handles your health information, or if you otherwise believe that your privacy rights have been violated by Young Life, your complaint should be directed to:

The Young Life Benefits Department
Attention: Privacy Official
420 North Cascade Avenue
Colorado Springs, CO 80903
(719) 381-1800

If you are not satisfied with the manner in which Young Life handles a complaint, you may submit a formal complaint to the U.S. Secretary of Health and Human Services in Washington, DC.

There will be no retaliation by Young Life if you file a complaint.