



# CAMPING HEALTH, CONSENT AND RELEASE FORM

### FOR AREA DIRECTORS

Area # \_\_\_\_\_  
 Area Name \_\_\_\_\_  
 Trip Leader/Area Dir. \_\_\_\_\_  
 School Name \_\_\_\_\_  
 Camp Dates \_\_\_\_\_  
 Camper  Leader  A-Team   
 Summer Staff  Work Crew

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; it may not be used for any other camping trip. A new form must be completed for each Young Life Camp experience.**

**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; and
3. Proof of physical examination, verified by Physician's signature, required for ALL guests attending Beyond Malibu or camps located in CO or MN (Crooked Creek, Frontier Ranch, RMR, Trail West, Wilderness Ranch, or Castaway).
4. Pregnant and Post-Delivery Teens: Pregnant teens up to 34 weeks 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 to full term 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.

**Please make a copy for your records. Camps are unable to fax or send copies to other camps.**

Email \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_  
Last First Middle Initial

Parent or Guardian (or spouse) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
Street Address City State/Province Zip

Business Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Second Parent or Guardian Emergency Contact \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
Street Address City State/Province Zip

Business Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Street Address City State/Province Zip

If not available in an emergency, notify: Name \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
Street Address City State/Province Zip

### ACCIDENT COVERAGE

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.

- My insurance company** \_\_\_\_\_ **Policy Number** \_\_\_\_\_  
**Insurance company address** \_\_\_\_\_
- Not currently insured** – Young Life reserves the right to subrogation if it is later determined that personal medical insurance was in place.

PROVIDE Insurance Information

**Health Care Recommendations: A physician's signature must be on file at time of registration for teens and adults attending Beyond Malibu, or camps located in CO or MN, or a pregnant teen up to 34 weeks or teen giving birth 12 weeks prior to camp (see above). A parent can complete the following health care recommendations if these conditions do not apply.**

- 1.) Does applicant have a medical condition such as sickle cell or respiratory or other ailment or condition which would preclude participation at camps with an altitude of 7-14,000 feet? Yes \_\_\_\_\_ No \_\_\_\_\_
- 2.) In my opinion, the applicant's condition  does  does not preclude his/her participation in an active camp program.
- 3.) The applicant is authorized to carry an inhaler, epi pen and other emergency medications with them at all times? Yes \_\_\_\_\_ No \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

I have examined the applicant within the past 12 months. Date examined \_\_\_\_\_

Licensed Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_ Print Name \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Date of form completion \_\_\_\_\_ \*By \_\_\_\_\_ (\*Initial if completed by nurse or physician's assistant)

DOCTOR SIGN

The applicant is under the care of a physician for the following condition(s) \_\_\_\_\_

Any treatment or medication to be continued at camp (specify dosages) \_\_\_\_\_

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 allergies (food, drugs, plants, insects) \_\_\_\_\_

Any medically-prescribed meal plan or dietary restrictions \_\_\_\_\_

Any camp activities from which child should be excluded? (CO and AZ camps have rigorous activities at elevations from 7-14,000 feet.)

Name and phone of family physician (if attending camp outside of CO & MN) \_\_\_\_\_

Name and phone of dentist/orthodontist \_\_\_\_\_

<b>IMMUNIZATION HISTORY:</b> Required immunizations will be determined locally. Record month and year of basic immunizations.			<b>HEALTH HISTORY</b> (Give approximate dates)			
DPT:	Diphtheria	1	1	_____ Frequent Ear Infections	_____ Chicken Pox	_____ Epilepsy
	Pertussis (Whooping Cough)	2	2	_____ Heart Defect/Disease	_____ Measles	_____ Mononucleosis
	Tetanus	3	3	_____ Diabetes	_____ German Measles	_____ Convulsions
TD:	Tetanus			_____ Bleeding/Clotting Disorder	_____ Mumps	_____ last 60 days
	Diphtheria			_____ Hypertension	_____ Hepatitis A	_____ Sickle Cell
	Oral Polio (Sabin) TOPV			_____ Currently Pregnant	_____ Hepatitis B	
	Injectable Polio (SALK)			_____ Has delivered baby	_____ Hepatitis C	
	MMR I & II (Measles, Mumps, Rubella)			_____ in last 12 weeks		
	Other			<b>Allergies/Asthma</b> (Date not needed)		
	Tuberculin test given (most recent)			_____ Hay Fever	_____ Penicillin	
	Haemophilus influenza b (HIB)			_____ Ivy Poisoning, etc.	_____ Other Drugs	
	Hepatitis B			_____ Insect Stings	_____ Asthma	
	Chicken Pox (New York camps only)			_____ Other (specify)		

**ALTERNATE TRANSPORTATION ARRANGEMENTS**

The following people are allowed to pick my child up from camp \_\_\_\_\_

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.

Signature of parent or guardian or adult camper/staffer \_\_\_\_\_ Date \_\_\_\_\_

← SIGN

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.

Signature of parent or guardian or adult camper/staffer \_\_\_\_\_ Date \_\_\_\_\_

← SIGN

Camper may carry emergency medications and use as prescribed. Parent/Guardian \_\_\_\_\_ 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](http://www.younglife.org).

Signature of parent or guardian or adult camper/staffer \_\_\_\_\_ Date \_\_\_\_\_

← 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.

Signature of parent or guardian or adult camper/staffer \_\_\_\_\_ Date \_\_\_\_\_

← SIGN

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.

Signature of parent or guardian or adult camper/staffer \_\_\_\_\_ Date \_\_\_\_\_

← SIGN

I also understand and agree to abide with the restrictions placed on my camp activities as listed herein.

Signature of minor or adult camper/staffer \_\_\_\_\_ Date \_\_\_\_\_

← SIGN

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

Printed name of minor or adult camper/staffer \_\_\_\_\_ Date \_\_\_\_\_

← 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.