

MEDICAL INFORMATION

INFORMED CONSENT

Name _____ Date _____ Date of Birth _____

Address _____

Phone # _____ Email _____

Physician and Phone # _____

Emergency Contact _____ Phone # _____

List known allergies _____

List required medications and times to administer _____

If you are allergic to bee stings, do you have a bee sting kit? _____

Do you wear contact lenses? _____ Are you pregnant? _____

Have you had or do you have (circle if yes) Diabetes Asthma Angina Epilepsy Chest pains
Drug reactions High blood pressure Heart murmur Heart Attack (if yes, date _____)

Have you ever had any serious disease or surgery? (if yes, date, and explain)

Do you have any other medical conditions that we should be aware of?

I do hereby agree to hold free and harmless Changing Course Foundation, and any chartered affiliates, agents, servants, employees, officers and directors from all costs and expenses including but not limited to: attorneys' fees, reasonable investigation and discovery costs, court costs, and all other sums the above mentioned persons may pay or become obligated to pay on account of any, all and every demand for claim or assertion of liability, or any claim or action founded thereon, arising or alleged to have arisen out of you or your child's use of real or personal property belonging to Changing Course Foundation and, or by any action or omission by you or your child also for any accident or injuries that might occur during any activity or connected with any activity. I also give permission to the Changing Course Foundation Health Officer or other Camp Health personnel to administer common over-the-counter medications as may be prudent and indicated when necessary to alleviate such common ailments as headaches, stomachache, nausea, pain, allergies, ECT. In addition, I give my permission for the Health Officer to administer any necessary first aid treatment or emergency treatment or to secure treatment by a doctor or hospital as may be needed. In addition, I consent to treatment s may be needed by a doctor, ambulance medics or at a hospital if such becomes necessary. I authorize the Health Officer to secure transportation as may be indicated or required, via personal vehicle driven by an adult staff member or via ambulance or CareFlite, when necessary to transport to a doctor or hospital.

I am not under the influence of any chemical substance including alcohol. Understanding that any physical activity involves a risk of injury, I understand that my participation in the Changing Course Foundation program is entirely voluntary. I release Changing Course Foundation, and all its' employees from any claims or liability arising out of my participation.

This form good from _____ to _____.

Name _____ Participants signature _____

Date _____ If the participant is under age 18, parent of guardian must also sign below:

Guardians Printed Name

Contact Number

Guardians Signature

Photo Media Release

I grant Changing Course Foundation the right to use, reproduce, assign and distribute photographs, films, videotapes, DVD's, and sound recordings of myself or my child for use in promotional materials they may create.

Signature: _____ Date: _____