

Activity & Medical Release

FRBA Missions Camp at Camp Tehama

July 15 – July 19, 2018

Participant's Name: _____

Address: _____

City/State/Zip: _____

Church: _____

Age: _____ **Birthday:** _____ **Grade Completed:** _____

Name of Parent/Guardian: _____

Address (If different from above): _____

City/State/Zip: _____

Employed by: _____

Phone Number (_____) _____ Cell Number: (_____) _____

May photographs taken of this participant be used for promotional purposes? ____ yes ____ no

For Office Use Only

Participant's Name: _____

Are you currently taking medicine or treatment? ____ yes ____ no

If yes, explain: _____

Have you been restricted from sports or swimming for any reason? ____ yes ____ no

If yes, explain: _____

Date last Tetanus Toxoid Immunization: Month: _____ Year: _____

Have you ever had a severe reaction to a bee / hornet sting or insect bite? ____ yes ____ no

Do you have: ____ sinus trouble ____ hay fever ____ heart trouble ____ epilepsy
____ asthma ____ diabetes

List any Allergies:

Food: _____

Drugs: _____

Other Medical Needs: _____

Insurance Company: _____

Policy Number: _____

If I cannot be reached, please notify: _____

Phone Numbers: _____

Anything else we should know about the participant: _____

EMERGENCY MEDICAL AUTHORIZATION & ACTIVITY WAIVER

In consideration of the permission granted to the participant named above, by the above-named Sponsor, to participate in the above described Activity, I hereby release said Sponsor, its agents and employees, from all actions, causes of action, damages, claims, or demand which I, my heirs, executors, administrators, or assigns may have against said Sponsor and other above described parties for all personal injuries known or unknown which the participant named above, has or may incur by participating in the above described activity.

In the event of an emergency, I hereby give permission to the church-appointed sponsors, FRBA staff, and/or camp personnel, who are with my child (above-named participant) at the above mentioned event to obtain medical assistance for my child. I also give permission to the physician selected to hospitalize and secure proper treatment for my child.

I, the undersigned, have read this release and understand all its terms. I execute it voluntarily and with full knowledge of its significance.

In witness whereof, I have executed this release on this _____ day of _____ 2017.

Participant's Signature: (If 18 or older) _____

Parent / Guardian's Signature: _____