Medical and Liability Release Form
Please Bring on Check-in Day

Camper Name: (Last) _____ (First) _____

Camp Session: _____ Date: _____

MEDICAL/LIABILITY RELEASE

LIABILITY RELEASE AND WAIVER

As the legal guardian of *(camper name)* _____ I understand the nature of camp activities and that the camper is qualified, in good health, and in proper physical condition to participate and acknowledge that if the camper believes conditions are unsafe, the camper will immediately discontinue participating in the activity. I fully understand that participating in activities or use of any facility or equipment of THE ARK CHRISTIAN MINISTRIES, or engaging in or receiving instruction in any activity or activity incidental thereto some of which may involve dangers and risk of serious bodily injury, including permanent disability, paralysis and death which may be caused by the participant's own actions, or inactions, those others participating in the event, the conditions of which the event takes place, or the negligence of the "releases" named; at: THE ARK CHRISTIAN MINISTRIES in the city of Converse, County of Grant, and the State of Indiana. Participation gives THE ARK CHRISTIAN MINISTRIES permission to use participant's image in publicity materials (photos, videos, quotes). I understand that some camp activities may take the participants off the premises of The Ark Christian Ministries.

It is the intention of the participant and legal guardian by this agreement to exempt and relieve THE ARK CHRISTIAN MINISTRIES and its officers, agents, servants, and employees, other participants, sponsors, advertisers, and if applicable owners or lessors of premises on which the activity takes place, from liability for personal injury, property damage, or wrongful death of the participant caused by any act of negligence. The undersigned participant and guardian agrees that in the event any claim for personal injury, property damage, wrongful death, or otherwise, caused by any act of negligence will indemnify and hold harmless THE ARK CHRISTIAN MINISTRIES and its officers, agents, servants, and employees, other participants, sponsors, advertisers and if applicable, owners or lessors of premises on which the activity takes place.

CONSENT FOR MEDICAL TREATMENT AGREEMENT

I/We hereby authorize the management of THE ARK Christian Ministries in the city of Converse, Grant County, Indiana, to consent to any necessary examination, medical diagnosis, surgery or treatment and/or hospital care to be rendered to the above-named minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine in the United States of America. I/We accept all financial responsibility for the medical treatment of the participant/camper named above.

Camper Signature _____ Phone # _____ Date _____

Parent/Guardian _____ Phone # _____

Emergency Contact 1 _____ Phone # _____

Emergency Contact 2 _____ Phone # _____

MEDICAL HISTORY

CAMPER MEDICAL HISTORY FORM

Family Doctor _____ Phone # _____

Health Insurance Carrier _____ Member's Name _____

ID# _____ Benefit Code _____ Account # _____

HEALTH HISTORY

[The following information must be filled in by the parent/guardian.] The intent of this information is to provide health care personnel the background to provide appropriate care. Please provide complete information so that the camp can be aware of your camper's needs.

Please use the back for additional writing space.

Has your camper or anyone in your family been sick the week prior to camp? ☐ Yes ☐ No

Illness _____ Family Member _____

Please check all, past or present, which apply to your child.

☐ ADHD
☐ Asthma
☐ Behavior Problems
☐ Convulsions/Seizures
☐ Diabetes
☐ Heart Trouble
☐ Hemophilia
☐ High Blood Pressure
☐ Joint/Bone Issues
☐ Rheumatic Fever

Please explain any boxes checked above: _____

Please list any pertinent medical information:

(EX: Allergies to medication, food, insects, hay fever, etc. and reactions, conditions or recent surgeries)

MEDICATION

CAMPER MEDICATION FORM

Please document any medication you are sending with your camper on this sheet. This form helps health care personnel provide optimum care for your camper. Before arriving at camp please make sure: ***ALL MEDICATIONS ARE IN THE ORIGINAL CONTAINERS. ALL PRESCRIPTION MEDICATIONS MUST BE LABELED WITH THE CORRECT NAME OF THE CAMPER.***

Medication	Dosage Directions and Route	Frequency and Time

Please check any of the boxes below to pre-approve these medications to be given to your child as needed.

☐ Tylenol/Ibuprofen ☐ Eye/ear drops ☐ Antihistamine/Benadryl ☐ None of these