

**Military Teen Adventure Camp
PARTICIPANT HEALTHFORM**

We require the original of this document be sent to the address below as early as possible before the event you are attending. Participation is dependent on our possession of this form.

If necessary, you may FAX this form to 509-667-6561; but you MUST mail the original to the address below.

**Military Teen Adventure Camp
WSU Extension Chelan County
400 Washington Street
Wenatchee, WA 98801**

Attendance dates: from: _____ to _____

Participant Name: _____
First Middle Last

Male Female Birth Date _____ Age on arrival at program _____
Mont/Day/Year

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To Parent(s)/Guardian(s): Please read and follow all instructions on this form. Attach additional information if needed.

1. Complete pages 1, 2 and 3 of this form (and make a copy for yourself).
2. Send the original, signed form to program by requested date.

Participant Name: _____
First Middle Last
 (For Camp Use) Cabin or Group _____
 (For Program Use) Session Code(s) _____

Participant Home Address: _____
Street Address City State Zip Code

Parent/guardian with residential placement and/or decision-making authority in the event of illness or injury:

Name: _____ Relationship to Participant: _____

Preferred Phones: (_____) _____ (_____) _____ Email: _____

Home Address: _____
(If different from above) Street Address City State Zip Code

Second parent/guardian with legal responsibility/authority to be contacted in case of illness or injury:

Name: _____ Relationship to Participant: _____

Preferred Phones: (_____) _____ (_____) _____ Email: _____

Additional parent/guardian to be contacted in case of illness or injury:

Name: _____ Relationship to Participant: _____

Preferred Phones: (_____) _____ (_____) _____ Email: _____

Allergies: No known allergies. This participant is allergic to: Food Medicine The environment (insect stings, hay fever, etc.) Other
(Please describe below what the participant is allergic to and the reaction seen, in detail. Please describe preventative or responsive measures.)
 This participant has a life-threatening allergy. An emergency care plan signed by physician is required.

Diet, Nutrition: This participant eats a regular diet. This participant eats a vegetarian diet (describe details below).
 This participant has special food needs. *(Please describe below.)*

Immunizations:

My child is up-to-date on his/her immunizations and tetanus shots as required by Washington State law. Date of last Tetanus shot: _____

My child has an immunization exemption on file with his/her school. I understand and accept the risks to my child from not being fully immunized.

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.

Has the participant:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)?..... Yes No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?..... Yes No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?..... Yes No
4. Had a significant life event that continues to affect the participant's life?..... Yes No
(History of abuse, physical or sexual trauma; conduct disorders such as oppositional defiance, developmental disability, Autism Spectrum Disorder?, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)
5. Depression (Bipolar)?..... Yes No

Please explain "Yes" answers in the space below, noting the number of the questions. The staff may contact you for additional information.

**Military Teen Adventure Camp
PARTICIPANT HEALTH FORM**

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Participant Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does this participant:

- | | | | |
|--|--|---|--|
| 1. Ever been hospitalized?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. If female, have problems with periods/menstruation?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever had surgery?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Have problems with falling asleep/sleepwalking?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Ever had back/joint problems?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Have a history of bedwetting?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Have problems with diarrhea/constipation?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Has asthma/wheezing/shortness of breath?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Have any skin problems?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have diabetes?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Traveled outside the country in the past 9 months?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Had seizures?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 21. Had Sickle Cell disease or traits?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Had headaches?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 22. Had high blood pressure? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 23. Had cardiovascular disease or other heart problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Had fainting or dizziness?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 24. Have a history of heart disease (not limited to conjunctive heart defect, cardiomyopathy, ahybrythemia?)..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Passed out/had chest pain during exercise?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 13. Had mononucleosis ("mono") during the past 12 months?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

- Medication:**
- This participant will not take any daily medications while attending the activities.
 - This participant will take the following daily medication(s) while attending the activities.¹

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. **All medications must be in their original containers. Prescriptions must have the child's name and how the medication should be given printed on the prescription container. Please send only those medications that are necessary.**

Name of medication	Date started	When it is given	Amount or dose given	How it is given
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Other time: _____		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Other time: _____		
		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Other time: _____		

- Restrictions:**
- I have reviewed the program and activities of the program and feel the participant can participate without restrictions.
 - I have reviewed the program and activities of the program and feel the participant can participate with the following restrictions or adaptations. **(Please describe below.)**

¹ Note: These provisions regarding administration of medication shall not abrogate minors' rights to provide their own consent to certain services under Washington law.

WASHINGTON STATE UNIVERSITY (WSU)
MILITARY TEEN ADVENTURE CAMP ACTIVITIES
For Parents or Guardians of Participants Under 18 Years of Age
ASSUMPTION OF RISK

I understand that there are risks in participating in outdoor adventure camps and associated outdoor activities including but not limited to rock climbing, river rafting, ropes course, downhill skiing etc as part of participation in the Military Teen Adventure Camp activities through Washington State University (WSU) and Chelan County.

In consideration for and as a condition of being allowed to participate in this voluntary activity, I agree to take full responsibility for any and all risks that exist, including the risk of death or injury to my child or loss or damage to my property. I understand that there may be risks that WSU and Chelan County cannot predict or foresee, and I also assume full responsibility for those risks.

Risks in participating in the Military Teen Adventure Camp activities involve travel by vehicle, raft or boat in remote areas with very limited access to telephones and other typical daily conveniences. Overnight accommodations may require sleeping on the ground in sleeping bags under tarps or in tents. Due to the nature of the activities participants will be subjected to walking and/or climbing on uneven surfaces including but not limited to steep slippery and unmaintained trails, rocks, gravels and river bank slopes, and snow or ice covered ground or terrain. The potential for injuries include, but are not limited to: temporary or permanent muscle soreness, sprains, strains, cuts, abrasions, bruises, ligament and/or cartilage damage, orthopedic damage, head, neck or spinal injuries, loss or use of arms and/or legs, eye damage, disfigurement, burns, drowning or death. I also recognize that there are both foreseeable and unforeseeable risks of injury or death that may occur as a result of participation in or traveling to or from the Military Teen Adventure Camp activities that cannot be specifically listed. Further, I recognize that the actions of other participants in the activity may cause harm or loss to my child or property.

RELEASE OF LIABILITY

I release Chelan County, the state of Washington, the Regents of WSU, WSU, any subdivision or unit of WSU, its officers, employees, and agents, from any and all liability, claims, costs, expenses, injuries and/or losses to person or property, which I may sustain and/or sustain as a result of death or injury of my child, as a result of or connected with participation in the above event. My child's participation includes, but is not limited to, travel to and from the event in a private or public vehicle, any activity connected with the event itself, and use of state or County equipment or facilities for the event whether on or off WSU or County property. **I have carefully read this document, understand its contents and am fully informed about this program and circumstances. I am aware that this document is a contract with WSU and the program sponsors. I sign it freely and voluntarily.**

DATED THIS _____ DAY of _____, _____.

Name of Parent or Guardian: (Please Print)

Parent or Guardian Signature:

Name of Minor (Printed): _____

Name and Likeness Release Form

I, _____ grant a nonexclusive permission to
(Please print your name)

Military-Extension Adventure Camps, Washington State University and WSU Chelan County Extension to use my name, likeness, and/or materials presented, in a photo or as part of a video and/or audio recording and digital file that Military-Extension Adventure Camps is producing for the purpose of broadcast, Internet or digital distribution, and/or other such use.

I fully understand the nature of this commitment and will endeavor to cooperate with all reasonable requests made by Military-Extension Adventure Camps. I further attest that I do control all permissions on the material I am presenting, and I am granting permission to Military-Extension Adventure Camps by signing this agreement.

In consideration for granting this permission, I understand that I am to receive no monetary remuneration for any appearance(s) and/or presentation(s). I also give Military-Extension Adventure Camps permission to use the recording(s) containing myself and the materials presented, as noted above, for its purposes and at its discretion, in perpetuity.

Signature _____ Date _____

Signature of Parent or Guardian _____ Date _____

(Parent's signature is required for those under age 18; guardian's signature is required for legally incapacitated persons and for any minor for whom a guardian is appointed.)

Individual, Business, or Department Name (PRINTED): _____

Phone: _____

Title and Date of Event or Production/Program: _____

Please mail or fax completed form to:

Military-Extension Adventure Camps
WSU Chelan County Extension
400 Washington Street
Wenatchee, WA 98801
Fax: 509-667-6561

For office use only.

For Military-Extension Adventure Camps: _____ Date: _____



[Your logo or title here.]

