



Indiana Camper Health Form

(required for each student)

_____ M F
Last Name First Name MI Age

_____ Church Affiliation
Address

_____ Birth date
City State Zip County

Camper Email (for our use only) _____

Immunization Record:

Are your child's immunizations up to date? Yes No If No, please explain _____

Health History:

Check if these apply to your child:

- _____ Asthma
- _____ Epilepsy
- _____ Diabetes
- _____ Cardiac Issues
- _____ Behavior (Please describe – i.e., bedwetting, nosebleeds, headaches, sleepwalking, etc.)

Allergies:

- Aspirin _____
- Penicillin _____
- Other Drugs (list) _____
- Foods (list) _____
- (if your child has a severe food allergy please have your youth leader contact us at 231-734-2616 to make arrangements.)

Precautions to be observed: _____

Operations or injuries: _____

Medication:

Drug	Purpose	Dosage
_____	_____	_____
_____	_____	_____

Personal Insurance Information:

Insurance Company: _____ Policy #: _____

Group or Employer: _____ Phone #: _____

In the event of accident or illness, parents are completely responsible for any necessary treatment costs incurred.

In case of emergency call: _____ Phone:(_____) _____

Family Doctor: _____ Phone:(_____) _____

I hereby certify that the above health record is, as of this date, accurate and complete.

Signature of Parent or Guardian

Date Completed

I. LIMITED PURPOSE POWER OF ATTORNEY: CONSENT TO TREATMENT OF A MINOR

A. The undersigned hereby appoint:

_____ (Your Group Sponsor) _____ (Your Group Sponsor)

Bill Dinsmore (IN Vice President), Carey Edgren (IN Camp Director), or Keith Rudge (Site Manager)

each to act alone, and delegate to each such person the power to consent on our behalf to all emergency treatment and/or medical care (except elective surgery) of _____ (**Child's Name**) determined to be necessary or desirable by the child's attending physician at the hospital.

B. This Power of Attorney shall continue until revoked by the undersigned, or for six (6) months after its date, whichever is earlier. Physicians or the hospital's medical staff may assume and rely that this authorization is currently in effect during such six month period unless notified.

II. LIABILITY WAIVER

I recognize that certain hazards and dangers are inherent in the SpringHill events and programs and particularly, but not limited to, the activities of horseback riding, swimming, high adventure areas, paintball, extreme sports, winter tubing, snowboarding, ice skating, and cross-country skiing, and I acknowledge that although SpringHill has taken safety measures to minimize the risk of injury to participants, SpringHill cannot insure nor guarantee that the participants, equipment, premises, and/or activities will be free from hazards, accidents, and/or injuries. I further recognize and have instructed my child in the importance of knowing and abiding by the camp's rules, regulations, and procedures for the safety of activity participants.

In consideration of SpringHill accepting and permitting my child to attend camp and participate in the camp's high adventure activities, I agree that SpringHill, a non-profit corporation, its agents, officers, employees, trustees and volunteers will not be liable for any injury, death, damage and/or loss to my child, and/or anyone claiming on my child's behalf, and I further agree to hold harmless, indemnify and defend SpringHill, its officers, agents, employees, trustees and volunteers for and from any and all damage during the time of my child's attendance and participation at SpringHill, whether such injury, illness, or damage occurs on or off the camp's premises.

III. PHOTO RELEASE

I certify that photographs or videotape pictures of my child participating in the SpringHill programs may be reproduced and utilized in promotional materials for the camp.

DATED: Month _____ Day _____ Year _____

Father: _____ Home Phone (_____) _____
Name
_____ Work Phone (_____) _____
Address

City State Zip County

Email Employer

Mother: _____ Home Phone (_____) _____
Name
_____ Work Phone (_____) _____
Address

City State Zip County

Email Employer

I represent that I am the parent or legal guardian of _____ (child's name), that I am at least eighteen (18) years of age and I am under no mental or legal disability which would prevent me from signing and executing this agreement. I further represent that I have read (or have had read to me) and understood the terms of this agreement.

Father/ Guardian Signature Date Mother/Guardian Signature Date

Witness Signature Date Witness Address Witness City State Zip
(Signature must be witnessed by a person over 18 yrs old, other than your immediate family)