



Acknowledgment of Risk And Optional Publicity Release

Revised 2/05/2009

INSTRUCTIONS: Please read this form carefully. **EACH PARTICIPANT MUST SIGN THIS ACKNOWLEDGMENT OF RISK FORM BEFORE the program begins. Without all appropriate signatures, the individual may not be permitted to participate in the program.**

I understand that my participation in programs offered by Joy Outdoor Education Center, LLC and Joy Outdoor Education Center Foundation, Inc., (JOEC) is based on a "Challenge by Choice" philosophy. I recognize that the program is designed to use experiential, engaging, teaching techniques, but that my participation is purely voluntary, and I elect to participate in spite of the risks.

I am aware that experiential, outdoor pursuits such as living history reenactments, climbing, hiking, high ropes courses, ground initiatives, and other activities at JOEC, for which I have enrolled, entail certain risks.

I understand that completing and signing the Center's Confidential Medical Information Form is a prerequisite to participate in this program. The information my child or I have provided is a complete and accurate statement of the physical and psychological factors, which may affect participation in the program.

Therefore, I, for myself and for my heirs, personal representatives, and assigns, and each of them, forever release and fully discharge Joy Outdoor Education Center, LLC and Joy Outdoor Education Center Foundation, Inc., and each of their members, managers, directors, employees, volunteers, agents, officers, predecessors, affiliates, representatives, successors, and assigns, and each of them, from any and all actions, causes of action, claims, costs, damages, demands, fees, and/or liability of any kind, nature, or descriptions whatsoever, whether know or unknown, arising out of or in any way related, whether directly or indirectly, to any psychological injury, loss of life or personal property that may occur as a result of participating in this program.

I have read and understand and accept the terms and conditions stated herein and acknowledge that this agreement shall be effective and binding upon the parties during the entire period of participation in the said program.

The health history is correct as far as I know, and the named participant has permission to engage in all prescribed camp activities, except as noted. Authorization for treatment: I hereby give permission to the medical personnel selected by the visiting organization to arrange necessary related transportation for this participant and the visiting organization or JOEC to secure and administer treatment, including hospitalization, for the person named above.

8 _____ 8 _____
Signature of participant (REQUIRED) **Date** **If participant is under 18, Date**
(Signature of Parent or Guardian is REQUIRED)

NOTE: This participant shall **NOT BE PERMITTED** to participate in the following activities:

Please indicate whether you give your consent for yourself or your child to be photographed or videotaped for general camp, website, and / or agency publicity. **I GIVE MY CONSENT** **I DO NOT CONSENT**

PERMISSION FOR PUBLICITY (OPTIONAL)

I, the undersigned, give my consent for my child to be photographed for general camp and/or agency printed / internet publicity.

Signature of parent/legal guardian _____ **Date** _____



Camp Joy Medical Form

INSTRUCTIONS: Please read and complete this form carefully. **PLEASE PRINT**

PARTICIPANT'S LAST NAME: _____ **FIRST:** _____
Circle One: Male / Female **Circle One:** Chaperone / Participant **Participant's Birth Date:** / / **Age:** _____
Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Phone (____): _____
Primary Contact: _____ **Relationship:** (Parent / Guardian / Spouse / Other): _____
Primary Contact #'s: Home: (____) _____ Work: (____) _____ Other: (____) _____

IF PRIMARY CONTACT IS NOT AVAILABLE - IN AN EMERGENCY NOTIFY: (List 2 contacts at 2 different addresses)
1. Name: _____ **Relationship:** _____ **Address:** _____
City: _____ **State:** _____ **ZIP:** _____
Home # (____): _____ **Work # (____):** _____
2. Name: _____ **Relationship:** _____ **Address:** _____
City: _____ **State:** _____ **ZIP:** _____
Home # (____): _____ **Work # (____):** _____

PHYSICIAN & INSURANCE INFORMATION

Medical/Hospital Plan: _____ **Policy or Group #:** _____
Policyholders First & Last Name: _____ **Employer:** _____
Primary Physician's Name: _____ **Phone:(____):** _____
Family Dentist's Name: _____ **Phone:(____):** _____

IMMUNIZATIONS / RESTRICTITONS

Immunizations: DPT Date _____ Tetanus Date _____ **Have you had Chicken Pox? Circle:** Yes No
List any dietary restrictions: _____
List any activity restrictions: _____
List anything else, which would help us, better serve you: _____

MEDICAL CONDITIONS

- Tissue Transplant - Date of Transplant: _____
- Organ Transplant - Date of Transplant _____
- Type of organ transplanted _____
- Asthma (Does participant carry an inhaler?) _____
- Broken Bones _____
- Diabetes _____
- Ear Infections _____
- Headaches _____
- Heart Disease _____
- High Blood Pressure _____
- Infectious Hepatitis _____
- Psychiatric Care _____
- Pregnancy _____
- Fainting _____
- Convulsions / Seizures / Epilepsy _____
- Date of last Seizure: ____/____/____

ALLERGIES: Check all that apply

- Hay Fever _____
 - Insect Stings _____
 - Poison Ivy, other plants: _____
 - Peanuts, other foods: _____
 - Penicillin, Other drugs: _____
 - Latex _____
- Describe Allergic Reaction:** _____

Does participant carry an Epi-pen? _____
(If yes, please send Epi-pen with participant.)

Completed upon arrival by Staff:

Completed By: _____
Date: _____ **Cabin #** _____ **Session #** _____
 _____ Looks and feels well _____ Any skin conditions
 _____ Recent injuries _____ Head lice or scalp problem
 _____ Physical challenges/disabilities?
Additional information for the health care provider:

Please describe management of the above conditions or allergies.
 : _____

PARENTAL ACKNOWLEDGMENT AND CONSENT

The health history is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted.
Authorization for treatment: I hereby give permission to the medical personnel selected by Joy Outdoor Education Center, LLC (JOEC) to provide routine health care, administer prescribed medications, and seek emergency medical treatment, including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes; I give permission to JOEC to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by JOEC to secure and administer treatment, including hospitalization, for the person named above. I give permission to the JOEC medical staff to assist my child with over-the-counter medication if needed.

Signature of Parent/Legal Guardian _____ **Date** _____