

Lone Tree Camp Adult Retreat Registration/ Health History Form

Lone Tree Camp Attending Ranch Fort Lakeshore Missions

Please circle one

Information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care.

(The top section to be filled in by adult campers/ staff members themselves.)

Date of Camp _____ Date of Birth _____ M/F _____ Age _____ Name of Church/Group _____

Name _____

Home Address _____

City _____ State _____ Zip _____ Phone (____) _____

Occupation _____ Work Phone (____) _____

Email Address _____ Check box if you do **Not** want to receive Lone Tree emails.

In case of emergency notify:

Name _____ Phone (____) _____

Relationship _____

Name of Physician _____ Phone (____) _____

Chronic or recurring illnesses or medical conditions (stomach upsets, rash, frequent colds, etc) _____

List any current medication being taken and why they are needed _____

Operations or serious injuries (dates) _____

List any Swimming or Activity Restrictions _____

Insurance Company _____

Insurance Company Phone# (____) _____

Insurance Policy Number

Please attach photocopy of front and back of Insurance Card (helpful in emergencies).

If you or your child should require medical attention while at one of the Lone Tree Camps for injuries received or illnesses contracted prior to coming, please send information necessary to give him/her proper medical service during this time.

In case of emergency, I hereby give permission to the physician selected by the camp director or his staff to hospitalize, secure proper treatment for and order injection, anesthesia or surgery for me or my child as named above. I also hereby give my permission for me or my child to participate in all activities, including but not limited to Swimming, Boating activities, Blobbing, Bike ramp, River float, Hot Springs, Field Sports, Mountain Rappelling, Vehicle Transportation, Climbing, Waterslide, Mechanical Bull, Archery, Rifle Range, Hayrides, Horseback Riding, Cycling, Zipline Swings, Caving, Digglers Mountain Scooters.

I am also responsible for securing transportation for my child from camp, pick up will be supervised and approved by myself or by the designated on-site leader that attends camp with the camper's church or school group.

I agree to assume, as an explicit condition of my or my child's/ward's participation, any all risks, including, but not limited to these enumerated above. **I agree to release, discharge and hold harmless Lone Tree Inc., its staff, the sponsoring church or group and its members from any and all liabilities, claims, demands and causes of action whatsoever which may arise due to the participation of myself or my child/ward.**

I realize, also, that in the event of illness or injury while attending camp or participating in its activities, medical treatment may be required, I hereby give permission for any such treatment to be rendered, and **I agree to bear the cost** of such treatment. If any changes occur, I will contact the director in writing.

Periodically, photographs, videos, or interviews are taken during the camp session. I acknowledge that by my or my child's/ward's participation in a Lone Tree camp session, I give permission and consent for any such photographs, videotapes or interviews to be used or published to illustrate, report, promote or advertise the camp.

Health History

(Check if applies. Give approximate dates.)

- Frequent Ear Infections _____
- Heart Defect/Disease _____
- Convulsions/Epilepsy _____
- Diabetes _____
- Bleeding/Clotting Disorders _____
- Hypertension/A.D.D. _____
- Mononucleosis _____

Disease

Vaccination

(Check if applies. Give approximate dates.)

- | | |
|---|-------|
| <input type="checkbox"/> Chicken Pox | _____ |
| <input type="checkbox"/> Measles | _____ |
| <input type="checkbox"/> German Measles | _____ |
| <input type="checkbox"/> Mumps | _____ |
| <input type="checkbox"/> DPT | _____ |
| <input type="checkbox"/> TD | _____ |
| <input type="checkbox"/> Tetanus Test | _____ |
| <input type="checkbox"/> Tuberculin Test | _____ |
| <input type="checkbox"/> Influenza b (HB) | _____ |

List any allergies (include food allergies)

Current Treatment for above:

SIGNATURE

DATE