PATHWAYS, INC. HEALTH FORM

Health information on this form is held confidential unless there is a medical emergency

BASIC INFORMATION

Camper Name: _____ Program Attending: _____
Address: _____ Dates Attending: _____
City: _____ Birthdate: _____
State: _____ Zip Code: _____ Age: _____ Sex: _____ Gender:_____

EMERGENCY CONTACT INFORMATION

1. Parent/Guardian (if under 18): _____ Primary Phone Number: _____
Address (if different than above): _____
2. Parent/Guardian (if under 18): _____ Primary Phone Number: _____
Address (if different than above): _____

HEALTH INSURANCE INFORMATION

Insurance Company: _____ Policy Number: _____
Full name of policy holder (if you do not have health insurance, please list your SS#):
_____
Primary Care Provider: _____ Clinic/City: _____
Clinic Address: _____ Clinic Phone Number: _____

HEALTH HISTORY

If participant has had in the past, please give approximate date(s), If participant **HAS NOW**, please mark with a "N"

_____ADD/ADHD
_____Anorexia/Bulimia
_____Constipation
_____Diabetes
_____Ear Infections
_____Hepatitis
_____Ulcers
_____German Measles/Rubella
_____Mumps
_____Bronchitis
_____Seizures (Please describe.)
_____Asthma (Please have your inhaler readily available, if needed)
_____Appendicitis
_____Convulsions
_____Diarrhea
_____Fainting Spells
_____Chicken Pox
_____Heart Defect/Disease
_____Measles
_____Tonsillitis
_____Bleeding Disorders
Other: _____
_____Arthritis
_____Depression
_____Nervousness/Anxiety
_____Headaches
_____Hypertension
_____Mononucleosis
_____Sinus Trouble
_____Rheumatic Fever
_____Cramps

ALLERGIES

_____Hay Fever _____Insect Stings _____Food Products _____Other: _____
_____Poison Ivy _____Penicillin _____Other Drugs

IMMUNIZATIONS (give approximate dates)

_____DPT Permanent Shots _____Tuberculin _____Polio Immunization _____MMR _____Tetanus Booster
_____Other: _____

MEDICATIONS

Does this person take medications on a regular basis? ☐ YES ☐ NO
If yes, please list **ALL** medications (prescription and non-prescription) taken routinely: _____
_____
May acetaminophen/ibuprofen be administered if needed? ☐ YES ☐ NO

ABILITIES & OTHER

Other Illness or needs that may affect participation? _____
Surgeries or serious illness & dates? _____
Dietary Restrictions? _____Any activities restricted by a physician? _____

Signature: _____ **Date:** _____
(Guardian must sign if participant is under 18 years of age)

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Pathways, Inc.

Assumption of Risk, Medical Authorization, and Publicity Consent Form

By signing this release form I agree to release and hold harmless Pathways Inc., its agents, employees, facilitators, and others, (hereby referred to as "Pathways, Inc.") for any damage or injuries, physical or mental, which I might incur as a result of my voluntary decision to participate in all facets of a Pathways, Inc. program, which may or may not include the Challenge Course program at Camp Emmaus/Character Challenge Course Company in Park Rapids, MN.

If I do voluntarily choose to participate in the program, I recognize that there is a significant element of risk in any adventure, sport, or activity associated with the outdoors. Knowing the inherent risks, dangers, and rigors involved in the activities, I certify that I am fully capable of participating in the activities. I understand that Pathways, Inc. has the right to deny participation if there are any safety concerns.

I assume full responsibility for myself for bodily injury, sickness, disease, death, loss, or damage, and expenses thereof, as a result of my negligence, or other risks, including but not limited to those caused by the Challenge Course at Camp Emmaus, the terrain, the weather, my athletic and physical condition, and other participants.

By signing this release form, I agree that if I do sustain any physical injury or mental damage of any nature as result of my voluntary decision to participate in the Pathways, Inc. program, I voluntarily agree to hold harmless and release the above named parties from any liability therefore and that this release is binding on my heirs and assigns. I agree to accept financial responsibility for any medical expenses and/or loss of income not covered by my insurance policy. In the event of an emergency, I authorize the Pathways, Inc. staff to seek emergency medical treatment.

By signing below I authorize Pathways, Inc. to use any photos or video taken during the visit to Pathways, Inc. in publicity materials for Pathways, Inc.

I acknowledge that I have been given the opportunity to ask questions regarding any aspect of this release form and by signing in the space provided below I do acknowledge that I have read completely and fully understand all aspects of this release form and agree to its terms in its entirety.

_____	_____
Print Participant Name	Date of Program
_____	_____
Participant Signature	Date
_____	_____
Signature of Parent or Guardian (if under 18)	Date
_____	_____
Print name of parent or guardian	Telephone