

# Howell Conference & Nature Center

1005 Triangle Lake Rd. Howell, MI 48843 • Office # 517-546-0249 Fax # 517-546-1677 • www.howellnaturecenter.org

## Agreement to Participate for MINORS

Group/School/Camp Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Guardian's Names \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Email Address \_\_\_\_\_

I understand that at the Howell Conference and Nature Center, I am expected to follow all the rules as presented by the Challenge Program facilitator, Ropes staff, & EE staff including, but not limited to: listening and following safety instructions, running is not allowed, no negative comments to other participants, respect for adults in charge and other participants, and positive encouragement given to other participants. I fully realize that participation in the high ropes, low ropes, initiatives, obstacle, tower, zip line, wall climbing courses ("Courses"), Global Village, and all Environmental Education classes involves psychologically and physically challenging situations and that my participation in the same could result in injuries including but, not limited to: sprains, cuts, rope burns and/or abrasions or more serious injury. I acknowledge that the Howell Nature Center ("HNC") has/will informed me of all required safety regulations and that my failure to follow the regulations and instructions may result in serious injury.

/s \_\_\_\_\_  
**PARTICIPANT'S SIGNATURE** **DATE**

I understand that a physician should be consulted before participation in these courses if my child has one of the following conditions: is pregnant, has a back condition, high blood pressure or a heart condition. I understand that an inhaler for exercised induced asthma, an Epi-pen for severe insect allergies or any other medication needed for a chronic medical condition should be brought with my child to the challenge courses. I acknowledge that my child's participation in the Courses means I accept the dangers that are open, obvious and necessary to these activities.

I agree to hold the **Howell Conference and Nature Center and the Presbytery of Detroit, Inc., its sponsors, agents, representatives, board members, employees, contractors and suppliers harmless for any and all damages which my child might sustain and suffer in connection with my child's participation in the Courses, programs, and activities at HNC.**

The HNC has my permission to secure emergency care for my child if necessary. I accept full responsibility for the cost of any treatment for any injury suffered while participating in the Courses. I understand that any photographs taken of my child participating in the Courses or programs may be used for publicity.

### **MEDICAL STATEMENT**

I recognize that climbing can be a strenuous endeavor requiring my child to be in good physical condition.

I am listing below those conditions my child has that could restrict my child's participation in the Challenge Courses, and activities while at camp at the HNC.

Medications currently taking: \_\_\_\_\_

I further certify that to the best of my knowledge, I attest that I have disclosed all information that could restrict my child's participation in this activity.

**IF PARTICIPANT IS UNDER EIGHTEEN (18) YEARS OF AGE, SIGNATURE OF BOTH PARENTS IS REQUESTED IN ADDITION TO PARTICIPANT'S SIGNATURE.**

/s \_\_\_\_\_  
**PARENT/GUARDIAN SIGNATURE IF MINOR IS UNDER EIGHTEEN (18) YEARS OF AGE** **DATE**

/s \_\_\_\_\_  
**PARENT/GUARDIAN SIGNATURE IF MINOR IS UNDER EIGHTEEN (18) YEARS OF AGE** **DATE**

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## Permission Slip and Health History Form

### To be completed by parent or guardian

Dates and Name of Camp Attending \_\_\_\_\_

Camper Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Home address \_\_\_\_\_  
Street address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Custodial Parent/Guardian \_\_\_\_\_ Home # \_\_\_\_\_

Email Address \_\_\_\_\_

Place of work \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Emergency contacts \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
Street address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If not available in an emergency, notify \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
Street address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Insurance Information

Is the participant covered by family medical/hospital insurance? \_\_\_\_ Yes \_\_\_\_ No

Policy Holder's Name \_\_\_\_\_

Carrier or Plan Name \_\_\_\_\_ Policy # \_\_\_\_\_

Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Important !! This box must be complete for attendance!

**Parent/Guardian Authorizations:** I give permission for my child to attend the Howell Nature Center camps. This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I give permission for the camp First Aid personnel to provide routine health care, administer prescribed medications, and first aid treatment on site. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for my child, in the event I cannot be reached in an emergency. I give permission to the physician or the aforementioned camp First Aid personnel to hospitalize secure proper and/or routine treatment and to order injection, anesthesia, x rays, or surgery for my child in the event I cannot be reached in an emergency. This completed form may be photocopied for trips out of camp.

I give permission for my child to be interviewed and pictures taken to be used by the Howell Nature Center or other news media to help with the promotion of the Howell Nature Center camps or related events.

\_\_\_\_\_  
(Signature of parent or guardian) Date \_\_\_\_\_

\_\_\_\_\_  
(Signature of parent or guardian) Date \_\_\_\_\_

**Restrictions:** (The following restrictions apply to this individual.)

**Does not eat:** \_\_\_ Red Meat \_\_\_ Pork \_\_\_ Dairy Products \_\_\_ Poultry \_\_\_ Seafood \_\_\_ Eggs \_\_\_\_\_ Other \_\_\_\_\_

**Health History:**

**Allergies:** List all know. Describe reaction and management of the reaction.

**Medication Allergies (list)** \_\_\_\_\_

**Food** \_\_\_\_\_

**Other (insect stings asthma, animal)** \_\_\_\_\_

**Medications Being Taken:**

This Person takes NO Medications on a routine basis.

Please list all medications (including over-the-counter nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (If prescription drug), the name of the medication, the dosage, and the frequency of administration.

**This person takes medications as follows:**

<u>Medication</u>	<u>Dosage</u>	<u>Hours given</u>	<u>Reason</u>

I hereby give permission to administer the over-the-counter medications listed below, or their generic equivalents EXCEPT THOSE I HAVE CROSSED OUT if the Camp Health officers deem it necessary. Dosages will be administered according to directions on the bottle unless a physician directs otherwise.

Tylenol	Benadryl	Cough drops	Tums	Pepto Bismol	Robitussin
Motrin	Contac	Eye drops	Aloe Cream	Caladryl lotion	Hydrocortisone cream

**General Questions** (Explain "yes" answers below)

Has/does the participant:		Yes	No	Yes	No	
1. Had any recent injury or illness or infectious disease?.....	___	___	___	9. Ever been hospitalized?.....	___	___
2. Have a chronic or recurring illness/condition?.....	___	___	___	10. Ever had surgery?.....	___	___
3. Have frequent headaches?.....	___	___	___	11. Ever had a head injury?.....	___	___
4. Ever been knocked unconscious?.....	___	___	___	12. Wear glasses, contacts or protective eye wear?....	___	___
5. Ever have frequent ear infections?.....	___	___	___	13. Ever have seizures?.....	___	___
6. Ever been diagnosed with a heart murmur?.....	___	___	___	14. Ever had back problems?.....	___	___
7. Have any skin problems? (itching, rash, acne)?.....	___	___	___	15. Have diabetes?.....	___	___
8. Have asthma?.....	___	___	___	16. Have a history of bed-wetting?.....	___	___

Please explain any yes answers, noting the number of the questions. \_\_\_\_\_

**Which of the following has the participant had?**

\_\_\_ Measles \_\_\_ Chicken Pox \_\_\_ Mumps \_\_\_ German measles \_\_\_ Hepatitis A or B or C

**My Child's Vaccinations are Up To Date/Current:**  YES  NO Please Initial \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardians Initials