



To the Physician, Licensed Nurse Practitioner, or Physician's Assistant,

Beyond Malibu is located in Princess Louisa Inlet British Columbia, Canada and has been safely providing both hiking and sea kayaking wilderness adventure experiences in the remote inlets and mountains of the Coastal Mountain range since 1970.

A participant on a Beyond Malibu mountain trip will travel approximately 15 -30 miles during their 6 days on the trail with daily hiking distances of approximately 5 to 8 miles per day. This can vary given the group's ability and circumstances. They travel at elevations ranging from sea level to 8500 feet with daily ascents or descents of 900 to 3500 feet. Each day they camp along the trail in tents. Temperatures can range from freezing to 80 degrees Fahrenheit. They will be hiking up and down mountains, trails, over rocks, alpine vegetation, and on snow fields. They will be carrying a backpack and supplies which can weigh between 30 and 50 pounds, or approximately 1/3 their body weight.

We have found that people who are in overall good health with average physical ability can successfully complete the Beyond experience.

In the interest of the personal safety of both the participant and the other trip members, we are asking you to assess this applicant's physical, emotional and mental wellbeing. Please review the participants completed Young Life Adventure Camp Individual Guest Health and Consent Form ensuring that it is complete and it lists all of the participant's medical conditions, allergies and treatments. On the PHYSICIAN section, please answer the 3 questions in light of the participant's medical history and the trip description above.

Thank you.

Sincerely,

Camping Administration



YOUNG LIFE CAMPING HEALTH, CONSENT AND RELEASE FORM

FOR AREA DIRECTORS

Area # _____
 Area Name _____
 Trip Leader/Area Dir _____
 Camp Dates _____
 Camper Leader Assigned Team
 Summer Staff Work Crew Adult Guest

Information in this document is protected by HIPAA privacy laws and should be handled accordingly.

This form is only good for travel and attendance at this specific camp. A new form must be completed for each

Young Life Camp experience.

Note to Parent/Guardian/Guest: Young Life wants the camp experience to be a safe and healthy one. It is important that we have the following information, which will be shared with appropriate staff, to keep you or your child safe at camp and in the event of an accident or illness.

However, in the event of an accident or illness, it is important that we have the following information:

1. Medical history & medical insurance information
2. Proof of physical examination, verified by physician's signature, required for specific guests attending Beyond Malibu or camps located in CO or MN (Castaway, Crooked Creek, Frontier Ranch, Rocky Creek Ranch, RMR, or Wilderness Ranch). See Health Care Recommendations section below for additional information.
3. Pregnant and Post-Delivery Teens: Pregnant teens and teen moms 6 to 12 weeks post-delivery on camp date must have a physician's release. **Teen moms less than 6 weeks post-delivery on camp date may not attend. Pregnant teens over 34 weeks are not allowed to attend camp. Pregnant teens over 30 weeks may not attend Washington Family Ranch, Beyond Malibu, Wilderness Ranch, or remote rental camps.**
4. A physician's release is required for all infants 6-12 weeks on camp date and for infants attending any CO or MN camps. Infants younger than 6 weeks on camp date may not attend any camp. Infants younger than 12 weeks may not attend Washington Family Ranch, Malibu Club, Beyond Malibu, Wilderness Ranch, or remote camps.

Name _____ Birthdate _____ Gender Male Female Age _____
Last First Middle Initial

Parent/Guardian/Spouse _____ Email _____ Cell Phone (____) _____

Home Address _____ Home Phone (____) _____
Street Address City State/Province Zip

Work Address _____ Work Phone (____) _____
Street Address City State/Province Zip

Second Parent/Guardian _____ Email _____ Cell Phone (____) _____

Home Address _____ Home Phone (____) _____
Street Address City State/Province Zip

Work Address _____ Work Phone (____) _____
Street Address City State/Province Zip

If not available in an emergency, notify: _____ Cell Phone (____) _____

Home Address _____ Home Phone (____) _____
Street Address City State/Province Zip

Name of School Camper Attends (if applicable) _____

REQUIRED	<p>ACCIDENT COVERAGE: I understand that my personal insurance will be primary coverage for camper accidents and that Young Life's insurance is secondary up to a maximum of \$20,000 (\$4,000 for dental claims). Exception: If the total claim is less than \$250, Young Life will pay the full amount. On claims above \$250, Young Life will coordinate payments for deductibles and co-pays. Young Life's policy does not cover camper illnesses or pre-existing conditions. If you have questions, please contact Young Life's Risk Management at (719) 867-3600.</p> <p><input type="checkbox"/> Insurance company _____ Policy Number _____</p> <p>Insurance company address/Web address _____</p> <p><input type="checkbox"/> Not currently insured – Young Life reserves the right to subrogation if it is later determined that personal medical insurance was in place.</p>	REQUIRED
	<p>DOCTOR INFORMATION: Name of family physician _____ Phone (____) _____</p> <p>Name of dentist _____ Phone (____) _____ Orthodontist _____ Phone (____) _____</p>	

POSSIBLE PHYSICIAN SIGN	<p>HEALTH CARE RECOMMENDATIONS: This section must be completed by a <i>physician, nurse practitioner, or physician's assistant</i> for all individuals attending Beyond Malibu; all individuals attending camps located in MN; or a camper or work crew attending any Young Life camp who is pregnant or has given birth within 12 weeks of the camp date, or is a camper attending any camp in Colorado, or is attending Frontier Ranch, Crooked Creek Ranch, or Rocky Creek Ranch and is under the age of 18 at the time of submission, or is a camper, volunteer or leader attending Wilderness Ranch or RMR Backcountry and is under the age of 18 at the time of submission. Parent or adult applicant must complete this section if these conditions do not apply.</p> <p>1. Has the applicant been diagnosed with a medical condition or disease of the blood, respiratory, metabolic, or other system, such as sickle cell disease, COPD/emphysema, etc. that could limit participation at camps with an altitude 7-14,000 feet? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain the condition and expected treatments: _____</p> <p>2. Does the applicant have any additional medical conditions, including those above in #1 which could limit participation in an active camp program regardless of the elevation? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain the condition and expected treatments: _____</p> <p>3. The applicant is authorized to carry an inhaler, epi pen and other emergency medications with them at all times? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>PHYSICIAN'S SIGNATURE: (CO, MN, Beyond Malibu, pregnant/post-delivery teens/infants 6-12 weeks). Must be obtained within the same calendar year as the camp trip.</p> <p><input type="checkbox"/> I have examined the applicant within the past 12 months. Date examined _____ Height _____ Weight _____</p> <p>Physician Signature X _____ Date _____ Print Name _____ <small>May be signed by Physician, Nurse Practitioner, or Physician's Assistant</small></p> <p>Address _____ Phone (____) _____</p>	POSSIBLE PHYSICIAN SIGN
	<p>The applicant is currently under the care of a physician for the following condition(s) _____</p> <p>List any medication/treatment to be continued at camp (specify dosages) _____</p> <p>Any chronic or recurring illness or medical condition (including behavioral conditions); operations or serious injuries (include dates) _____</p> <p>Explanation of any reported loss of consciousness, convulsion or concussion _____</p> <p>Any camp activities from which applicant should be excluded _____</p>	
	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	

IMMUNIZATIONS	HEALTH HISTORY	
* If completing this form for an infant/toddler, camper or work crew attending a camp in the state of Colorado (Crooked Creek Ranch, Frontier Ranch, Rocky Creek Ranch, RMR Backcountry, Wilderness Ranch) and the attendee has been immunized, a state certificate of immunization must be attached to this form and presented at camp. Alternatively, a letter of exemption for religious reasons must be attached.		
<input type="checkbox"/> Check and date any immunizations the applicant has received, or <input type="checkbox"/> Applicant has not been immunized for: <input type="checkbox"/> medical <input type="checkbox"/> personal <input type="checkbox"/> or religious reasons.	Check if applicant has: <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding/Clotting Disorder <input type="checkbox"/> Convulsions in last 60 days <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy/Seizures <input type="checkbox"/> Frequent Ear Infections <input type="checkbox"/> Heart Defect/Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Sickle Cell <input type="checkbox"/> Neurological Condition	Has applicant had (include date): <input type="checkbox"/> Chicken Pox _____ <input type="checkbox"/> Measles _____ <input type="checkbox"/> German Measles _____ <input type="checkbox"/> Mumps _____ <input type="checkbox"/> Hepatitis A _____ <input type="checkbox"/> Hepatitis B _____ <input type="checkbox"/> Hepatitis C _____ <input type="checkbox"/> Mononucleosis _____
<input type="checkbox"/> DTaP (Diphtheria, Tetanus, & Pertussis) Date: _____ <input type="checkbox"/> TD (Tetanus and Diphtheria) Date: _____ <input type="checkbox"/> MMR (Measles, Mumps, Rubella) Date: _____ <input type="checkbox"/> Polio (OPV or IPV) Date: _____ <input type="checkbox"/> Hepatitis B Date: _____ <input type="checkbox"/> Varicella (Chicken Pox) Date: _____ <input type="checkbox"/> HIB (Haemophilus influenza B) Date: _____ <input type="checkbox"/> Other Date: _____	<input type="checkbox"/> Currently Pregnant Due Date: _____ <input type="checkbox"/> Delivered baby in last 12 weeks Delivery Date: _____	

ALLERGIES and DIETARY RESTRICTIONS (List any food, drug, plant, insect, or other allergies) Note – This information will be shared with appropriate staff.

<input type="checkbox"/> None	<input type="checkbox"/> Bees	<input type="checkbox"/> Dairy Intolerance	<input type="checkbox"/> Amoxicillin	<input type="checkbox"/> Other Allergies (Drugs, insects, plants, food, etc.) OR Dietary Restrictions – Describe below:
<input type="checkbox"/> Peanut Allergy	<input type="checkbox"/> Tree Nut Allergy	<input type="checkbox"/> Gluten Intolerance	<input type="checkbox"/> Fish Allergy	
<input type="checkbox"/> Shellfish Allergy	<input type="checkbox"/> Soy Allergy	<input type="checkbox"/> Egg Allergy	<input type="checkbox"/> Dairy Intolerance	
<input type="checkbox"/> Celiac Disease	<input type="checkbox"/> Gluten Intolerance	<input type="checkbox"/> Milk Allergy	<input type="checkbox"/> Vegetarian	
<input type="checkbox"/> Vegan	<input type="checkbox"/> Penicillin	<input type="checkbox"/> No Pork	<input type="checkbox"/> Sulfa	

PROTECTIVE CUSTODY ARRANGEMENTS

Is there a court order in place that lists certain persons who are or are not authorized to pick up your child from camp? YES NO

If yes, the following people are allowed to pick the camper listed from camp _____

If yes, the following people are NOT allowed to pick the camper listed up from camp _____

Signature of parent/guardian: X _____ **Date** _____

AUTHORIZATION FOR TREATMENT This health history is correct to the best of my knowledge, and the person herein named has permission to engage in all camp activities except as noted. I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to maintain and/or release any medical records necessary for insurance purposes as outlined under the HIPAA regulations*; and to provide or arrange necessary related transportation for the camper listed. In an emergency, I hereby give permission and authorize the medical provider selected by Young Life to secure or administer emergency medical treatment, including medical transportation and hospitalization and any other emergency medical procedures and services which may be needed for the person named herein. I authorize the medical provider or dentist to call in any necessary consultants in his/her discretion. It is understood that this consent is given in advance of any specific diagnosis or treatment being required, and is given to encourage those persons who have temporary custody of the minor, and said medical provider or dentist to exercise their best judgment as to the requirements of such diagnosis or medical, dental or surgical treatment. In addition, I authorize camper to carry emergency medications and use as directed.

Parent/Guardian/Adult Applicant Signature: X _____ **Date** _____

I agree to remain fully liable and responsible for the payment of any such hospital, doctor, medical transportation, dental or medical fees with the exception of the Accident Coverage as set out herein. I further agree that in giving this permission and authorization, Young Life does not assume any responsibility or liability for the payment of such hospital, doctor, medical transportation, dental or other medical fees which may be incurred. The completed forms may be photocopied and maintained by authorized personnel as needed including trips out of camp.

Parent/Guardian/Adult Applicant Signature: X _____ **Date** _____

I have received notice and agree to the release of my personal information and required health information as outlined in Young Life's "Privacy Statement." Available at www.trust.younglife.org.

Parent/Guardian/Adult Applicant Signature: X _____ **Date** _____

ACKNOWLEDGEMENT OF INHERENT RISK I ACKNOWLEDGE AND UNDERSTAND THERE ARE INHERENT RISKS ASSOCIATED WITH MANY CAMP ACTIVITIES. AS A GUARDIAN OR PARTICIPANT, I HAVE BEEN GIVEN THE OPPORTUNITY TO REVIEW THE ACTIVITIES THAT I OR MY CHILD MAY BE ABLE TO PARTICIPATE IN BY CLICKING ON FOLLOWING LINK AND REVIEWING THE CAMPING ACTIVITIES LIST (<https://camp.younglife.org/Pages/Camping-Activities.aspx>) ASSOCIATED WITH THE CAMP THAT I OR MY CHILD IS ATTENDING. I WILL ASSUME THE RISK ASSOCIATED THEREWITH, WHETHER KNOWN OR UNKNOWN TO ME AT THIS TIME. I RECOGNIZE THAT MY/MY CHILDS ATTENDANCE AT A YOUNG LIFE CAMP IS A PRIVILEGE AND AS A CONSIDERATION FOR THIS PRIVILEGE, I RELEASE YOUNG LIFE, INCLUDING ITS EMPLOYEES, AGENTS AND TRUSTEES, FROM RESPONSIBILITY FOR MY OR MY CHILD'S ACCIDENTAL PHYSICAL INJURY, INCLUDING DEATH OR ILLNESS, AND LOSS OF PERSONAL PROPERTY WHILE AT CAMP OR DURING YOUNG LIFE SPONSORED TRAVEL TO AND FROM CAMP. THIS RELEASE IS ALSO INTENDED TO INCLUDE ALL CLAIMS MADE BY MY FAMILY, ESTATE, HEIRS, PERSONAL REPRESENTATIVE OR ASSIGNS. I GRANT PERMISSION FOR MYSELF/ MY CHILD TO PARTICIPATE IN ALL SPECIAL TRIPS OFF THE CAMP PROPERTY WITH PROPER STAFF SUPERVISION. **MALIBU CLUB/BEYOND MALIBU:** I AGREE THAT ANY COMPLAINT, DEMAND, DISPUTE, CLAIM, INVOLVING BODILY INJURY INCLUDING DEATH, AND/OR PERSONAL INJURY OR CAUSE OF ACTION ARISING OUT OF OR IN ANY WAY RELATED TO YOUNG LIFE'S MALIBU CLUB OR BEYOND MALIBU, INCLUDING ANY ACTIVITY, EVENT, MEDICAL TREATMENT, AND/OR TRANSPORTATION WILL BE GOVERNED BY THE LAWS AND JURISDICTION OF THE CANADIAN PROVINCE WHERE THE EVENT OR INCIDENT OCCURRED.

WAIVER AND RELEASE IF I AM UNDER AGE 18 OR UNDER THE AGE OF 19 IF ATTENDING MALIBU CLUB OR BEYOND MALIBU, MY PARENT OR GUARDIAN, BY SIGNING BELOW, ALSO CONSENTS TO MY RELEASE AND HE OR SHE AGREES THAT THIS RELEASE SHALL BE BINDING UPON HIM OR HER AS MY PARENT OR GUARDIAN AS TO ME AND MY ESTATE, HEIRS, PERSONAL REPRESENTATIVES AND ASSIGNS. MY PARENT OR GUARDIAN ALSO PROMISES, BY SIGNING BELOW TO DEFEND, INDEMNIFY AND HOLD YOUNG LIFE HARMLESS FROM ANY CLAIM ASSERTED BY ME AGAINST YOUNG LIFE, INCLUDING ITS TRUSTEES, EMPLOYEES AND AGENTS, IF I SHOULD REPUDIATE THIS RELEASE AFTER OBTAINING ADULTHOOD.

Parent/Guardian/Adult Applicant X _____ **Date** _____

EQUINE ACTIVITIES RELEASE: UNDER COLORADO LAW, AN EQUINE PROFESSIONAL IS NOT LIABLE FOR ANY INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES, PURSUANT TO SECTION 13-21-119, COLORADO REVISED STATUTES. UNDER ARIZONA LAW, A SIGNED RELEASE ACKNOWLEDGES THAT THE PERSON IS AWARE OF THE INHERENT RISKS ASSOCIATED WITH EQUINE ACTIVITIES, IS WILLING AND ABLE TO ACCEPT FULL RESPONSIBILITIES FOR THEIR OWN SAFETY AND WELFARE AND RELEASES THE EQUINE OWNER OR AGENT FROM LIABILITY UNLESS THE EQUINE OWNER OR AGENT IS GROSSLY NEGLIGENT OR COMMITS WILLFUL, WANTON OR INTENTIONAL ACTS OR OMISSIONS. AS PROVIDED IN VIRGINIA CODE §3.2-6202 THE UNDERSIGNED ACKNOWLEDGES AND UNDERSTANDS THAT INHERENT RISKS MAY EXIST FOR PERSONS INVOLVED IN EQUINE ACTIVITIES DUE TO THE UNPREDICTABLE NATURE OF EQUINE'S REACTIONS TO THEIR ENVIRONMENT. SUCH RISKS MAY INCLUDE PERSONAL INJURY, HARM OR EVEN DEATH. THE UNDERSIGNED RELEASES THE EQUINE OWNER AND/OR ACTIVITY SPONSOR FROM ANY AND ALL LIABILITY WHICH MIGHT RESULT FROM THIS ACTIVITY.

PHOTO RELEASE I HEREBY GRANT PERMISSION TO YOUNG LIFE THE RIGHT TO USE, REPRODUCE, AND/OR DISTRIBUTE PHOTOGRAPHS, FILMS, VIDEOTAPES, AND SOUND RECORDINGS OF MYSELF/MY CHILD, WITHOUT COMPENSATION OR APPROVAL RIGHTS, FOR USE IN MATERIALS CREATED FOR PURPOSES OF PROMOTING THE ACTIVITIES OF YOUNG LIFE.

Parent/Guardian/Adult Applicant X _____ **Date** _____

Applicant understands and agrees to abide with the restrictions placed on his/her camp activities as listed herein. Parent/Guardian may sign for minor, acknowledging their agreement.

Parent/Guardian/Adult Applicant X _____ **Date** _____

(If camper is emancipated, proof must be provided prior to camp.)