



Participant Name (last, first): _____

Participant's Medical History & Physician's Statement

Must be filled out and signed by physician DOB: _____ Height: _____ Weight: _____

Address: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ Controlled: Y / N Date of Last Seizure: _____

Shunt Present: Y N Date of last revision: _____

Special Precautions/Needs: _____

Mobility please circle one: Independent Ambulation or Assisted Ambulation Device for ambulation: _____

Can patient tolerate jarring? (such as for ziplining, ropes course, etc): _____ (yes/no)

Does patient have any special transferring needs? If so, please explain: _____

Please indicate current or past special needs in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/ Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disabilities			
Cognitive			
Emotional/ Psychological			
Pain			
Other			

Camper weight: _____

Date of weight taken: _____ (Weight must be recorded at time of physical)

Brand name of scale used: _____

Signature of nurse/tech who took weight: _____

2nd signature for verification of weight: _____

****EXACT WEIGHT MEASUREMENTS ARE EXTREMELY IMPORTANT AT CAMP POSSIBILITY DUE TO WEIGHT LIMITS/RESTRICTIONS FOR ACTIVITIES, TRANSFER NEEDS, AND NEED FOR CAMP PHYSICIANS TO KNOW WEIGHT IF ANY MEDICATIONS ARE NEEDED WHILE THE PATIENT IS AT CAMP.**

*****This form must be filled out and signed by a Physician before returning to Camp PossAbility*****

Physician's Release

To my knowledge, there is no reason why this person cannot participate in recreational activities, waterfront activities (swimming/canoeing/water skiing/fishing/boat rides), music therapy, arts and crafts, archery, and high ropes initiatives (rock wall/zip line/alpine tower). However, I understand that Camp PossAbility will evaluate the medical information that has been provided in relation to the existing Bradford Woods and Camp PossAbility precautions and contraindications.

My signature below indicates

--that this patient weighs **NO GREATER THAN 250 pounds**

--that this patient has no open wounds

--this examination has been completed **AFTER July 1, 2018**

EXCEPTION: If this patient weighs GREATER THAN 250 pounds, they must be able to stand independently for 5 minutes and need absolutely NO ASSISTANCE WITH TRANSFERS.

--This exception applies for this patient (circle one) **YES/NO**

--I can verify that this patient is able to meet these requirements (circle one) **YES/NO**

Camper may participate in all camp activities excluding:

PHYSICIAN Name/Title (please print) _____ **MD DO NP PA other** _____

(No signature stamp accepted)

License/UPIN Number: _____

PHYSICIAN Signature: _____

Address: _____

Phone () _____ Date _____



Global Release

Program Name: _____ **Program Dates:** _____

Indiana University, through its Bradford Woods programs (hereinafter referred to as University), manages and conducts adventure and outdoor based programs. These activities are supervised by University staff, interns, and school personnel. Although novice skills will be taught and supervised by competent and experienced adult leaders, there is some degree of risk involved in the various activities and the ultimate safety of each participant will depend on the participants willingness to listen and to abide by the instructions, rules, and regulations given throughout the program.

The safety and well-being of each participant is of paramount importance to Bradford Woods and the professional staff, employees, and trustees of Indiana University. All reasonable care and precautions are taken to ensure a fun educational experience. The following “acknowledgment, assumption of risk and release of claims” is both a requirement of insurance coverage and an important reminder to you as a parent / guardian or participant to be sure that you or your child is properly prepared.

Acknowledgement, Assumption of Risk, and Release of Claims

Desires to participate in the program specified above. I understand the program offered through Bradford Woods may include, but is not limited to, the following potential hazardous activities: ground based initiatives, individual and group challenge activities, low, intermediate, and high ropes courses, hiking, camping, backpacking, caving, canoeing, other water based activities, fishing, archery, arts and crafts, environmental nature studies, transportation to and from activity sites and all other activities.

The inherent risks of these activities include the following: personal injury, property damage, illness, or death.

I understand that Bradford Woods does not require that I participate in the above-mentioned program.

In recognition of the potentially hazardous nature of the elective program, I, or my child, my heirs and assigns, hereby release Bradford Woods and the professional staff, employees, the trustees of Indiana University, and its agents from all claims of negligence arising from participation in the program. I further agree to hold harmless and indemnify Bradford Woods and the professional staff, employees, the trustees of Indiana University, and its agents for all defense costs, including attorney fees, and any other costs resulting in connection with my participation in this program.

I understand that this release relates to all claims and liability during and after the program resulting from a pre-existing medical condition. I have read and completed the medical history form provided by Bradford Woods and accept full responsibility for omissions or errors on the medical history form. I also understand that this release relates to all claims and liability resulting from unforeseen or intemperate weather. I have read the clothing list provided by Bradford Woods and accept full responsibility for inadequate clothing provided by me or those items which I fail to provide.

I have read this entire “acknowledgement and assumption of risk and release of claims” and fully understand the contents. My signature indicates that I have satisfied my questions and concerns regarding the above-mentioned program by talking with a representative of Bradford Woods.

Participant signature (Legal guardian’s signature if participant is under the age of 18) Date

Photographic Release

I hereby grant the University permission to take photographs, video recordings, and/or sound recordings of myself or my son or daughter. I grant the university permission to use the negatives, prints, motion pictures, video tapings, or any other reproduction of the same for educational and promotional purposes in manuals, on flyers, on the internet, or in any other manner deemed necessary. I declare that I have read and understand the contents of this PHOTOGRAPHIC RELEASE, and I am signing this as my free and voluntary act, irrevocably binding myself and my heirs.

Participant signature (Legal guardian’s signature if participant is under the age of 18) Date

Medical Services Permission Release

During participation in a Bradford Woods program, the Trustees of Indiana University, its agents, servants, and employees are hereby authorized to provide and secure any medical services, and authorize the diagnosis and treatment (including, but not limited to, surgery and the administering of anesthesia) of any injury or illness as in its judgment is necessary or advisable for the individual.

I hereby agree that the MEDICAL HISTORY provided in the camper application is true to my knowledge. I declare that I have read and understand the contents of the MEDICAL SERVICES PERMISSION and I am signing this as my free and voluntary act, irrevocably binding my heirs and myself.

Participant Signature (Legal guardian’s signature if participants is under 18) Date

Camper Name _____ 3

This form must be filled out and signed by a Physician before returned to Bradford Woods

Physician's Release

To my knowledge, there is no reason why this person cannot participate in horseback riding, recreational activities, waterfront activities (swimming/canoeing/water skiing/fishing/boat rides), music therapy, arts and crafts, archery, and high ropes initiatives (rock wall/zip line). However, I understand the Bradford Woods will evaluate the medical information that has been provided in relation to the existing Bradford Woods precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, SLP, Psychologist, etc), in the implementation of an effective equine activity program.

Camper may participate in all camp activities excluding:

PHYSICIAN Name/Title (please print) _____ MD DO NP PA other _____

PHYSICIAN Signature: _____

Address: _____

Phone () _____ Date _____

Insurance

Are you covered by hospitalization insurance? YES NO

Carrier: _____ Policy/Group#: _____

Medicare #: _____ Medicaid #: _____

A copy of your insurance, Medicaid or Medicare card is required. Please supply a copy of BOTH the FRONT and BACK of the card. Please provide a current picture that mainly shows your face.

**COPY of Front of Insurance
Card**

**COPY of Back of Insurance
Card**

**Recent Head Shot
(if you are a new camper)**