



Registration Form Offsite Adventures

This form may be submitted in lieu of an online registration. Completed forms must be returned to Amnicon at least 7 days prior to the start of the trip. This form must be signed by the participant's legal guardian and provide proof of medical examination from within 2 years of the trip. Either have a licensed medical practitioner sign the last page of the form, or attach a copy of a sports or school physical. For questions, please email info@amnicon.org or call 715-364-2602 ext 2.

Contact Information:

Participant Information:

Name: _____ Birthdate: _____ Age upon arrival at camp: _____
Sex: _____ Preferred Pronouns: _____ Group Reg Code: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Email: _____ Phone: _____ :

Primary Emergency Contact Information:

Name: _____ Relationship to participant: _____
Daytime Phone: _____ Evening Phone: _____
Email: _____

Secondary Emergency Contact Information:

Name: _____ Relationship to participant: _____
Daytime Phone: _____ Evening Phone: _____
Email: _____

Consent & Liability Release:

1. In consideration with the services of Camp Amnicon and all employees and persons associated with that business (hereinafter collectively referred to as "Camp Amnicon"), I agree as follows: Although Camp Amnicon has taken reasonable steps to provide me with appropriate equipment and skilled guides, Camp Amnicon has informed me that this activity is not without risk. Certain risks are inherent in each activity and cannot be eliminated without destroying the unique character of the activity. These risks include: loss or damage to my equipment, accidental injury, illness, or in extreme cases, permanent trauma or death. Camp Amnicon does not want to frighten me or reduce my enthusiasm for this activity, but believes it is important for me to be informed in advance of the inherent risks. I agree to accept and assume full responsibility for the inherent risks identified herein, and those inherent risks not specifically identified. My/my child's participation in this activity is purely voluntary, and I/my child agree(s) to participate in spite of and with full knowledge of the inherent risks. I acknowledge that while engaging in this activity I and/or my child have responsibilities as a participant. I acknowledge that I and/or my child have been or will be provided with a properly fitted, serviceable personal floatation device (PFD) before participating in any aquatic activities with Camp Amnicon, and that all participants are required to wear said PFD anytime they are in an aquatic vessel (canoe, kayak, paddleboard, or any other water craft). I acknowledge that the staff of Camp Amnicon are available to more fully explain to me the nature and physical demands of this activity and the inherent risks and hazards associated with this activity. I certify that I and/or my child are fully capable of participating in this activity. Therefore, I assume and accept full responsibility for myself/my child for bodily injury, death, or loss of personal property and expenses and any inherent risks and hazards not specifically identified, or anything that may result from my/my child's negligence while participating in this activity. I have carefully read, clearly understood, and accepted the terms and conditions stated herein and acknowledge that this agreement shall be effective and binding upon myself and all members of my family including my children.

2. This health history is correct and complete as far as I know. The person herein described has my permission to engage in all camp activities including those listed in the brochure, program information sheet, and "Information for Campers/Parents", except as noted. I hereby give permission to the camp to provide routine health care, dispense medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

3. I hereby authorize and consent to the use of my/my child's visual image, first name, likeness, voice and statements by Camp Amnicon to illustrate and promote the camp experience in media including but not limited to social media, print, and websites. I give this consent with no claim for payment. (If you wish you/your child to be exempt from use in camp media, you may cross out part 3.)

Guardian Signature: _____

Date: _____

(Or participant if they are over 18)

For Camp Use:

How is the Participant Feeling about the trip? _____

Notes from Health Interview: _____

Health Interview Completed?

(Initials & Date)

Insurance & Primary Care Providers:

Medical Insurance Information:

If the trip participant is covered by medical insurance please either attach a photocopy of the front and back of their insurance card, or complete the following section.

Insurer Name: _____ Provider Services Phone: _____
 Group #: _____ ID#: _____ Policy Effective Date: _____
 Subscriber Name: _____ Subscriber Birthdate: _____ Relationship: _____

Primary Care Provider:

If the trip participant has a primary care provider, please supply the following information:

Name of PCP: _____ Phone: _____
 Name of Dentist/Orthodontist: _____ Phone: _____

General Health History:

Select 'yes' or 'no' for each question. Please explain 'yes' answers in the space below.

Has/Does the participant:

- | | |
|------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|
| 1. Ever been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No | 10. Had a concussion?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Have a bleeding disorder?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have a recent/chronic illness/infection? <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Get frequent ear infections?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Have a recent/chronic injury?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Have problems sleeping? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Have back or joint issues?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Often gets diarrhea/constipation? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Have any skin conditions?..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Have migraines? <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Have problematic periods?.... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| 9. Have heart problems?..... <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Please explain 'yes' answers in the space below, noting the number of the question, and include any management strategies the participant will be using during the trip.

Allergies:

Please list ALL allergies below, including what reaction is seen and how reactions should be managed:

Dietary Restrictions:

- Does this trip participant have any dietary restrictions? Yes No
- Vegetarian
 - Gluten-Free
 - Dairy-Free
 - Nut/Peanut Allergy
 - Other (please list): _____

Immunizations:

- Date of most recent Tetanus shot: _____
- Did the camper get all the normal immunizations for school?
Yes No

Mental, Emotional, Behavioral Health:

Please select 'yes' or 'no' for each question.

Has/does the trip participant:

- 1. Ever exhibited, been diagnosed with, or been treated for ADD or ADHD? Yes No
- 2. Ever exhibited, been diagnosed with, or treated for a mood disorder? Yes No
(Depression, anxiety, OCD, BPD, etc...)
- 3. Ever exhibited, been diagnosed with, or treated for an eating disorder? Yes No
- 4. Ever exhibited, been diagnosed with, or treated for autism? Yes No
- 5. During the past 12 months seen a professional to address mental/emotional concerns?
- 6. Had a significant life event that continues to affect the camper's life? Yes No
(History of abuse, death of a loved one, family change, foster care, etc...?)

Please explain any 'yes' answers in the space below, including anything that might help the camper have a better experience on the trip:

Medications:

If the camper will be bringing any medications on the trip (including OTC and supplements) please provide the following information:

Name of Medication	Reason for taking	When is it given	Amount or dosage:	Other Instructions:

Attach additional information if necessary. Please send medications (including OTC & supplements) with their original pharmacy bottles in a waterproof plastic bag. A pill organizer may be sent in addition to the original pharmacy bottles. Make sure to send enough doses for the whole trip. If the camper is under 18, all medications will be given to the camper's guides who will administer the medication according to the dosage instructions.

Anything else?

Is there anything else you think we should know about this trip participant in order to help them have the best experience at camp? (Attach additional information if needed)

This page is to be completed by a medical professional.

To the Parent/Participant: A medical examination by a licensed practitioner from within 2 years of the trip is required for attendance. EITHER have your doctor complete this form, OR submit a copy of an After Visit Summary of a Well Check, School, or Sports Physical.

To Medical Personnel: Please review the enclosed form, and attach additional information as necessary. The person listed above will be participating in a wilderness trip lasting up to one week that will involve moderate physical exertion, frequent contact with water, and remoteness from immediate professional medical care. They will be doing activities such as canoeing, camping, hiking, and swimming. With questions call Camp Amnicon at 715-364-2602 ext 2.

Date of Exam: _____

Physical Information

Height: _____

Weight: _____

Blood Pressure: _____ / _____

Allergies:

Please list all allergies:

Dietary Restrictions:

Please list all dietary restrictions:

Contraindications

The following OTC medications are stocked in Amnicon's first aid kit and are given as needed to manage illness or injury. Please cross out any items below which should NOT be given to the camper listed at the top of this form:

Acetaminophen (Tylenol)

Ibuprofen (Advil)

Aspirin

Phenylephrine (Sudafed PE)

Diphenhydramine (Benadryl)

Bismuth Subsalicylate (Pepto Bismal)

Hydrocortisone 1% Cream

Dimenhydrinate (Dramamine)

Saline Eye-Wash

Ongoing Treatments:

This patient is undergoing treatment for the following conditions:

Medications:

Please list all medications the patient will be taking at camp (name, dosage, etc...)

Limitations or Restrictions:

Will the patient require any limitations or restrictions to activity while at camp?

Signature

"I have examined the patient. It is my opinion that this person is physically and emotionally fit to participate in this camp program."

Name: _____

Office Address: _____

Signature: _____

Phone: _____

Title: _____

Date: _____