

PATHWAYS, INC. YOUTH HEALTH HISTORY

Please bring this form with you to first day of camp. **Do not mail.**

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

Name _____ Camp Attending/Program _____
 Address _____ Week Attending _____
 City _____ State _____ ZipCode _____
 Birth date _____ Age _____ Sex _____
 Church _____ City _____ Pastor _____
 Parent/Guardian(if under 18) _____
 Home Phone _____ Cell Phone _____ Work Phone _____
 Address (if different than above) _____
 Emergency Contact (name and relationship) _____
 Home Phone _____ Work Phone _____

INSURANCE COMPANY _____ POLICY NUMBER _____
 FULL NAME OF POLICY HOLDER _____
 IF YOU DO NOT HAVE INSURANCE, LIST YOUR SS# _____
 FAMILY DOCTOR _____ CLINIC/CITY _____
 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	_____ Asthma (We require you have your inhaler readily available.)	
_____ Anorexia/Bulimia	_____ Appendicitis	_____ Arthritis
_____ Constipation	_____ Convulsions	_____ Depression
_____ Diabetes	_____ Diarrhea	_____ Bed Wetting
_____ Ear Infections	_____ Fainting Spells	_____ Headaches
_____ Hepatitis	_____ Nervousness	_____ Pregnant
_____ Ulcers	_____ Sleep Walking	_____ Homesickness
_____ Sinus Trouble	_____ Measles	_____ German Measles
_____ Mumps	_____ Tonsillitis	_____ Chicken Pox
_____ Bronchitis	_____ Bleeding Disorders	_____ Hypertension
_____ Heart Defect/Disease	_____ Seizures (Please describe.)	_____ Cramps
_____ Mononucleosis	_____ Rheumatic Fever	Other: _____

ALLERGIES

_____ Hay Fever _____ Insect Stings
 _____ Poison Ivy _____ Penicillin
 _____ Food Products _____ Other Drugs
 _____ Other: _____

IMMUNIZATIONS

(Give approximate dates)

_____ DPT Permanent Shots _____ Tuberculin
 _____ Polio Immunization _____ MMR
 _____ Tetanus Booster _____ Other: _____

Other illness or needs that may affect participation _____
 Surgeries or serious illnesses & dates _____
 Dietary restrictions _____
 Any restricted activities by physician _____
 Swimming ability: _____ Non-Swimmer _____ Beginner (avoids deep water) _____ Intermediate
(Note: If swimming should be restricted, please note under "restricted activities" above.)
 Other suggestions that may help make the participant's week more comfortable and enjoyable (fears...)

FEMALE:

Has this person menstruated?
 ___ YES ___ NO
 If not, has it been discussed?
 ___ YES ___ NO
 If so, is her menstrual history normal?
 ___ YES ___ NO

MEDICATIONS

Does this person take medications on a regular basis? _____
 If yes, please list **ALL** medications (prescription and non-prescription) taken routinely:

 May acetaminophen/ibuprofen be administered if needed? ___ YES ___ NO

People with the following medical conditions should consult a physician prior to attending the program.

1. If you have a **history of heart problems or high blood pressure**, you are at risk if you physically participate in this program. Due to the types of physical demands inherent to the activities, you may be jeopardizing your health and well being if you choose to fully participate.
2. If you are **pregnant**, you and your unborn child are at risk if you participate physically in this program. Unintentional impacts to your abdomen can occur during many of the activities that involve physical contact.
3. If you are **recovering from broken bones, dislocated joints, sprains, strains, back or neck injuries**, you are risking re-injury if you participate physically in this program.
4. If you have **an enlarged organ, are a transplant recipient, or have Downs Syndrome**, you are risking injury to the weakened areas of your body.

(PLEASE SEE REVERSE SIDE)

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.

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, 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

Address of participant

(PLEASE SEE REVERSE SIDE)