**CHALLENGER WEST 2016**

**Health and Insurance Form**

*Sponsored by:*

**United Church of God, *an International Association***

**PERSONAL INFORMATION (Please type or print clearly in all sections)**

Applicant's Name: Sex: Male Female Birth Date: / / .

First M.I. Last

Address: Phone: ( )

Street Address City State Zip

Social Security Number of Participant: - -

Parent/Guardian or Emergency Contact: Relationship:

Telephone: ( ) ( ) ( )

Home Work Other

Second Parent/Guardian/Emergency Contact: Relationship:

Telephone: ( ) ( ) ( )

Home Work Other

**MEDICAL / HEALTH HISTORY**

**Health History** – Explain any “yes” answers below

Does/did the participant have: **YES NO YES NO**

1. Recent injury, illness or infectious disease?..........

2. Mononucleosis in the past 12 months? .................

3. Chronic or recurring illness/condition? ..................

4. Diabetes? ..............................................................

5. Food allergies? ......................................................

6. Allergic to any medications (list below) .................

7. Respiratory problems or asthma? .........................

8. Frequent headaches, or migraines?......................

9. Ever passed out during or after exercise?.............

10. Ever been dizzy or faint during or after exercise? .

11. Ever experienced altitude symptoms? ..................

12. Ever had seizures?................................................

13. Ever had chest pain during or after exercise? .......

14. Heart murmur? ......................................................

15. High blood pressure? ............................................

16. Deep vein thrombosis? .........................................

17. Blood disorder? .....................................................

18. Back injuries or problems?....................................

19. Joint injuries? ........................................................

20. Sleepwalking? .......................................................

21. Eating disorder? ....................................................

22. Overweight or underweight? .................................

23. Emotional or mental difficulties for which

professional help was sought? ............................

24. (Females): Treatment for menstrual cramps?.......

25. (Females): Pregnant? ...........................................

If you checked “yes” to any of the above, please note the question # and explain, including any continuing medications needed.

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Please list all medications (including over-the-counter or other nonprescription drugs) taken routinely. Be sure to bring your medication with you  **in the original packaging** that will identify the doctor, the dosage and the frequency of administration:

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| --- | --- | --- | --- |
| **Medication** | **Dosage** | **Frequency** | **Reason for Taking** |
|  |  |  |  |
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**Do you have any health issues that *might* hinder you from participating fully in the program as described?** **Yes**  **No**

If yes, please describe in detail (attach note if necessary):

Which of the following has the applicant had? (Check each one that applies)

Measles Chicken Pox German Measles Mumps Rheumatic Fever

Hepatitis A Hepatitis B Hepatitis C TB Test (Date: , Pos or Neg? )

**Immunizations** – Fill in the dates for any of the following immunizations applicant has had.

|  |  |  |  |
| --- | --- | --- | --- |
| **Immunization** | **Date Last Received** | **Immunization** | **Date Last Received** |
| DPT |  | Mumps |  |
| TD (tetanus/diphtheria) |  | Rubella |  |
| Tetanus |  | Gamma Globulin (Hepatitis) |  |
| Polio |  | Chicken Pox |  |
| German Measles |  | Smallpox |  |

NOTE: A record of immunizations is for informational purposes. Immunizations are not a required prerequisite for acceptance or attendance. If a participant has not been immunized, however, and one of the above-named communicable or contagious diseases is found in the group, he or she will be subject to the regular quarantine or isolation procedures of the program and of the community for persons who are not immune.

|  |  |
| --- | --- |
| Name | **Who should be contacted in case of emergency?**  Relationship Home phone Cell phone Work phone |
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**ADULT APPLICANT:** I certify that to the best of my knowledge that this health history is accurate and complete, that I am in good health and able to participate in this program.

**Adult applicant signature:** Date

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**INSURANCE COVERAGE AND RELEASE**

Insurance Company: Policy or Group # Social Security Number of Policyholder or Insurance ID Number: Policyholder Date of Birth: Insurance Phone # ( ) Address: Family Physician: Phone: ( ) Address: Family Dentist/Orthodontist: Phone: ( )

Address:

**Personal Medical Insurance**

While we place a significant emphasis on safety at the Challenger West programs, accidents may happen and people may get injured. For this reason, we strongly recommend that you carry adequate personal medical insurance. We realize that it is not always affordable. However, paying actual hospital and doctor expenses can easily cost far more. As we review your application, this is an important factor in determining those most suited to participate in the program.

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**Supplemental Accident Insurance**

We realize that your personal insurance may require you to pay a deductible and co-payments, and possibly other costs. In an effort to help reduce the cost to you personally, the Church has been able to acquire supplemental accident medical coverage for a nominal cost. Though the Church is unable to provide financial assistance beyond what is offered through this insurance, we are happy to include all program participants in this coverage. The extent (amount and period) of accident coverage may vary from year to year. If you are accepted to this program, a copy of the coverage will be supplied upon request.

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**Release and Waiver**

I have read, fully understand, and agree to comply with all the rules and standards of the project and its staff. I understand and agree with its implications and the stated consequences. I also affirm that the information given this application is true and complete and that I am in good health and able to participate in the expected activities and routine for the project(s) marked on the front. In consideration of being allowed to participate, I hereby release, indemnify, save and hold harmless and covenant not to sue the United Church of God, *an International Association*, its officers, Council of Elders, agents, employees, volunteers and helpers and any other related entity (hereinafter collectively called the “Church”) from all actions, claims, demands or suits which are based upon, or result from injuries sustained, arising out of, or in the course of, participation or attendance at camp. This release, however, shall not apply to claims covered by the Church’s liability insurance (e.g. for its negligence) , but is applicable to claims not covered by that insurance. *It is strongly recommended that you have your own medical insurance protection* since participants are involved in activities at their own risk.

Signature

Date Signed

Print Name\_

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**MEDICAL EXAM / RECOMMENDATION AND RESTRICTIONS**

An exam by a medical practitioner is to be done within 24 months of participation in the program. Use the form below or attach a similar practitioner’s exam form. Submit your most current exam form for each program session.

**Applicant’s Name: Birth Date: / /**

I have examined the above named participant on / / (date). BP Weight Height In my opinion, the above applicant: is is not able to participate in an **active outdoor wilderness / adventure program that involves strenuous physical activity (backpacking, rock-climbing) in altitudes of 10,000+ feet.**

The applicant is under the care of a physician for the following conditions

Current treatment at the time of this report includes

**Recommendations and Restrictions for the Challenger II Program**

Treatment to be continued at camp

Medications to be administered at the program (name, dosage, frequency)

Any medically-prescribed meal plan or dietary restrictions

Known allergies

Description of any limitation or restriction on program activities

Additional information for health care staff at the program(use reverse side if necessary):

**Signature of Licensed Medical Personnel** Printed name Title Address

Phone Date

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