Release of Claims and Waiver of Liability

The undersigned applicant acknowledges, understands, and agrees that as to the contemplated trip with Expeditions Unlimited:

1. There are unique physical demands and risks involved in all activities;
2. Activities can be of a dangerous nature and may result in various types of injury including, but not limited to the following: Sickness, exposure to infectious/communicable disease, dislocations, broken bones, lacerations, abrasions, bruising, strains, sprains, etc. Paralysis, distress, damage, or death can result by participation in any activity.
3. That instructions given must be followed for ongoing participation and safety of the applicant; and
4. That Expeditions Unlimited, Ltd. retains the right of final approval of all participants and the right to terminate a participant's involvement in a trip at its discretion.
5. The Expeditions Warrior Challenge is an optional activity which entails unique physical demands and risk of injury to participants. I acknowledge these risks and give permission for my child to participate in this activity if they choose to do so.

In consideration of conducting the trip and based on the above, Expeditions Unlimited, Ltd., it's officers, directors, shareholders, employees, agents and their heirs, executors and assigns are released as to any and all claims for damages, including but not limited to injuries, whether to person or property, known or unknown that the undersigned has or may have in the future arising out of and in connection with the contemplated trip.

I hereby authorize Expeditions Unlimited to consent to emergency medical or dental care for me or my child while attending Expeditions Unlimited.

Release as to Photographic, Movie and Video Images
The undersigned irrevocably consents to and authorizes the use and reproduction of any and all photographic and video images taken during the trip. The use and reproduction of images is at the discretion of Expeditions Unlimited whether for advertising, promotional or other legal purposes without additional consideration or compensation to the undersigned. Originals and copies or images are and will remain the sole property of Expeditions Unlimited, Ltd.

Applicant Information
Complete the following information for each member of your household participating in the trip with Expeditions Unlimited.

Address

City/Sate/Zip

Phone

Applicant's Signature Date of Birth

Applicant's Signature Date of Birth

Applicant's Signature Date of Birth

Applicant's Signature Date of Birth

Applicant's Signature Date of Birth

Church/Organization: _____

Parent or Guardian Signature _____Date____/____/____
*Required if applicant is under 18 years of age

COVID-19 WAIVER OF LIABILITY

The undersigned applicant acknowledges, understands, and agrees that as to the contemplated trip with Expeditions Unlimited:

1. I understand the hazards of the novel coronavirus ("COVID-19") and I acknowledge and understand that the circumstances regarding COVID-19 are changing from day to day.

2. Notwithstanding the risks associated with COVID-19, which I readily acknowledge, I hereby willingly choose to attend Expeditions Unlimited and participate in activities.

3. I acknowledge and fully assume the risk of illness or death related to COVID-19 arising from my being on the premises and participating in the activities. Expeditions Unlimited, Ltd., it's officers, directors, shareholders, employees, agents and their heirs, executors and assigns are released as to any and all claims for damages, including but not limited to injuries, whether to person or property, known or unknown that the undersigned has or may have in the future arising out of and in connection with the contemplated trip.

Applicant's Signature: _____ DOB _____
*Required of all applicants regardless of age

Church/Organization: _____

Parent or Guardian Signature _____ Date____/____/____
*Required if applicant is under 18 years of age

CAMP HEALTH EXAMINATION FORM

Developed by the American Camping Association in consultation with The American Medical Association and the American Academy of Pediatrics

Name:_____ **Birth date:** _____**Gender: M:** ☐ **F:** ☐ **Age:**_____
Last First M. Init.

Name of Parents/Guardians
(or spouse): _____**Phone:**(_____)_____

Home Address:_____
Street City State Zip

Email Address:_____

Church/Organization:_____
If not available in an emergency, please notify:

1. _____Phone: (___)_____
   Name Relationship
2. _____Phone: (___)_____
   Name Relationship

Check all that apply

Health History

____ Frequent Ear Infections
____ Heart Defect/Disease
____ Asthma
____ Diabetes
____ Seizures

Allergies

____ Food Allergies **(Fill out included form)**_____
____ Aspirin
____ Insect Stings. List all types: _____
____ Penicillin
____ Other Drugs: _____

Allergies (describe reactions/treatment):

_____

Operations or serious injuries and dates:

_____

Chronic or recurring illnesses:

_____

Dentist/Orthodontist: _____Phone: (____)_____
Family Doctor: _____ Phone: (____)_____
Medical/Health Insurance Company:_____**Policy or Group #:**_____

IMPORTANT: *Please notify us if this individual is exposed to any communicable disease during the three weeks prior to attending.*

Medications: ***All medications must be in original pill bottles!***

Medication 1: _____ Dosage: _____ Administer at: (Check all that apply) ☐ breakfast ☐ lunch ☐ dinner ☐ bed ☐ other Reactions: _____

Physician: _____ RX#: _____ Route of Administration: _____ Date: _____

Medication 2: _____ Dosage: _____ Administer at: (Check all that apply) ☐ breakfast ☐ lunch ☐ dinner ☐ bed ☐ other Reactions: _____

Physician: _____ RX#: _____ Route of Administration: _____ Date: _____

(If more medications are necessary please use the back of this form)

IMPORTANT: MUST BE COMPLETED FOR ATTENDANCE

Parental Authorization. This health history is correct so far as I know, and the person described herein has permission to engage in all prescribed activities. In the event of an emergency, I hereby give permission to the physician selected by the Expeditions Unlimited staff to order X-rays, routine tests and treatment for the health of my child. In the event that I cannot be reached in an emergency, I also give permission to the physician selected by the Expeditions Unlimited staff to hospitalize, secure proper treatment for, to order injection and/or anesthesia and/or surgery for my child as named above.

Parental Signature:_____ **Date:**_____

Telephone (608) 356-4004
Fax (608) 356-4185

Food Allergy Action Plan

THIS FORM IS DUE BACK NO LATER THAN 2 WEEKS BEFORE YOUR RETREAT

*Completion of this form is necessary **only** if participant has a food allergy*

Name: _____

Group: _____

Allergy To: ☐ Dairy ☐ Wheat ☐ Eggs ☐ Peanuts ☐ Tree Nuts ☐ Other: (Please list)

_____

(We do not provide specialized meals for vegetarians, vegans, or other lifestyle choices. If you have a food allergy, we will do our best to accommodate your needs)

Physician:_____ Phone #:_____

Emergency Numbers
Name: _____ Phone #: _____

Name: _____ Phone #: _____

PLEASE TELL US WHAT TO DO IN CASE OF AN ALLERGIC REACTION
CHECK ALL THAT APPLY

This Occurs:
My Child's allergic reaction includes:

- ☐ Swelling, itching raised skin rash
- ☐ Generalized body flush, swelling or itching
- ☐ Nausea, abdominal cramps, vomiting and/or diarrhea
- ☐ Itching and swelling of lips, throat, or tongue causing hoarseness, swallowing difficulty, coughing, wheezing or shortness of breath.
- ☐ "Thready" pulse, "passing out"
  - These signs may occur
    - ☐ Within a few minutes
    - ☐ Within 30 minutes to 2 hours

The severity of symptoms can quickly change. All above symptoms can potentially progress to a life-threatening situation.

General First Aid

- Observe for 30 minutes
- Notify Parents
- ☐ Administer oral medication And
  Name _____ _____
  Dosage _____ _____
- ☐ Administer adrenaline (Epi Pen)
  - ☐ Immediately
- ☐ If symptoms occur (describe)

Student can self-administer Epi Pen? ☐ Yes ☐ No

If Epi pen is administered, an ambulance, then parents will be notified

*** ***Please Note***: *Expeditions Unlimited **cannot** provide specialized meals for participants but we can provide a couple of additional options, as well as inform students of the ingredients found in prepared food.*

Please return this form **2 weeks** prior to scheduled arrival date.
If returned later than **2 weeks** additional options may not be available.

Comments regarding other accommodations: _____

Parental Signature: _____ Date: _____

AUTHORIZATION TO ADMINISTER MEDICATION

Use of form: This form is mandatory for child care centers to comply with DCF 250.07(6)(f)1.a. Failure to comply may result in issuance of a noncompliance statement. This form is voluntary for group child care centers, day camps and certified providers; however, completion of this form meets the requirements of DCF 251.07(6)(f)1.a., DCF 252.44(6)(e)1.a. and DCF 202.08(4)(f) and 202.09(5)(c)., Wis. Admin. Codes. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: When a parent is requesting that the provider administer prescription or non-prescription medication to a child in care, this form shall be completed and signed by the parent or guardian before any medication is administered. A separate form shall be used for each medication. Place the form in child's file when medication is no longer required / authorized. Personal information you provide may be used for secondary purposes [Privacy Law, .15.04(1)(m), Wisconsin Statutes].

Personal information

Student Name_____

Birthdate_____

Medication Information:
Medication shall be in the original container and labeled with the child's name.

Name-medication	Dosage	Frequency of administration	Route of Administration	Physician	RX#	Poss/adv. Reactions.	Date Prescribed

I hereby authorize administration of the above medication to my child by staff of Christ Church.
Signature – Parent or Guardian

_____**Date**: _____

MEDICATION PERMISSION FORM

(Completed form required for ALL students)

Our nurse will have select over-the-counter medications on hand available to students as needed (i.e. headache, minor pain, etc.) during camp/retreat. A guardian's permission is required to administer these medications. *If you DO NOT give permission to staff to administer over-the counter medications without calling you first, a guardian still must complete this form.*

Child's Name: _____

Name and Date Camp/Retreat: _____

Parent's Printed Name: _____

Parent's Signature: _____

Parent's Cell Phone Number: _____

Date: _____

PLEASE SELECT ONE OF THE FOLLOWING OPTIONS:

☐ I **DO NOT** give permission to staff to administer medications listed on this form to my child without contacting me first.

☐ I **DO** give permission to staff to administer selected medications listed below per package directions to my child without contacting me first.

Please provide height, weight and age:

Child's Height: _____ Child's Weight _____ Child's Age _____

***Check all that apply*:**

☐ Tylenol (acetaminophen)

☐ Advil (ibuprofen, Motrin)

☐ Tums

☐ Benadryl (diphenhydramine)

☐ Claritin (loratadine)

PLEASE NOTE: NURSE WILL HAVE THESE MEDICATIONS ON HAND. NO NEED TO SEND ADDITIONAL WITH YOUR CHILD.

CHRIST CHURCH