Discovery Day Camp

APPLICATION AND REGISTRATION FOR YOUTH OR ADULT PARTICIPANT IN JURUPA MOUNTAINS DISCOVERY CENTER'S DISCOVERY DAY CAMP

Welcome to the Jurupa Mountains Discovery Center and our Discovery Day Camp program! Our trained staff and team of volunteers are equipped to provide your child with a fun and educational experience. Each week of camp is designed to focus on your child and to give him/her a memorable camp experience. Our goal is that every child has a desire to return year after year.

Child's Name: _____ Nickname: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____

City: _____State: _____Zip: _____

Phone: _____ Cell Phone: _____

E-mail: _____

Health/Accident Insurance Company: _____ Policy No.: _____

PLEASE ATTACH A PHOTOCOPY OF BOTH SIDES OF THE INSURANCE CARD. IF YOU DO NOT HAVE MEDICAL INSURANCE ENTER "NONE" ABOVE.

IN CASE OF AN EMERGENCY, NOTIFY THE PERSON BELOW:

Name: _____ Relationship: _____

Address: _____ Home phone: _____Other phone: _____

Alternate contact name: _____ Alternate's phone: _____

PART I: INFORMED CONSENT, RELEASE AGREEMENT, AND AUTHORIZATION

I understand that participation in Jurupa Mountains Discovery Center activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the staff, coordinators, or executive director. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

In case of an emergency involving me or my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or JMDC staff member. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the JMDC staff member to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose protected health information to the JMDC staff member, medical staff, and/or any physician or health-care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

(If applicable) I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any JMDC volunteers or professionals who need to know of medical conditions that may require special consideration in conducting JMDC activities.

With appreciation of the dangers and risks associated with programs and activities, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against Jurupa Mountains Cultural Center, dba Jurupa Mountains Discovery Center, aka JMDC, and all employees, volunteers, related parties, or other organizations associated with any program or activity. I also hereby assign and grant to Jurupa Mountains Cultural Center, dba Jurupa Mountains Discovery Center, aka JMDC, as well as their authorized representatives, the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child at all Scouting activities, and I hereby release Jurupa Mountains Cultural Center, dba Jurupa Mountains Discovery Center, aka JMDC, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all liability from such use and publication. I further authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of Jurupa Mountains Cultural Center, dba Jurupa Mountains Discovery Center, aka JMDC, and I specifically waive any right to any compensation I may have for any of the foregoing.

NOTE: Due to the nature of programs and activities, the Boy Scouts of America and local councils cannot continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. However, so that leaders can be as familiar as possible with any limitations, list any restrictions imposed on a child participant in connection with programs or activities below.

List participants restrictions if any: ☐ **None**

_____

_____

_____

_____

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity. If I am participating at Philmont, Philmont Training Center, Northern Tier, Florida Sea Base, or the Summit Bechtel Reserve, I have also read and understand the supplemental risk advisories, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met. The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider. If the participant is under the age of 18, a parent or guardian's signature is required.

PARTICIPANT'S SIGNATURE: _____ **DATE:** _____

PARENT/GUARDIAN SIGNATURE FOR YOUTH: _____ **DATE:** _____

SECOND PARENT/GUARDIAN SIGNATURE FOR YOUTH: _____ **DATE:** _____

COMPLETE THIS SECTION FOR YOUTH PARTICIPANTS ONLY:

ADULTS AUTHORIZED TO TAKE TO AND FROM EVENTS: You must designate at least one adult. Please include a telephone number.

NAME: _____ **NAME:** _____

TELEPHONE: _____ **TELEPHONE:** _____

ADULTS NOT AUTHORIZED TO TAKE YOUTH TO AND FROM EVENTS:

NAME: _____ **NAME:** _____

TELEPHONE: _____ **TELEPHONE:** _____

PART II: RECORD OF KNOWN HEALTH CONCERNS

YES	NO	CONDITION	EXPLAIN
☐	☐	DIABETES	(LAST HBA1C PERCENTAGE AND DATE)
☐	☐	HYPERTENSION (HIGH BLOOD PRESSURE)	
☐	☐	ADULT OR CONGENITAL HEART DISEASE/HEART ATTACK/CHEST PAIN (ANGINA)/HEART MURMUR/CORONARY ARTERY DISEASE. ANY HEART SURGERY OR PROCEDURE. EXPLAIN ALL "YES" ANSWERS.	
☐	☐	FAMILY HISTORY OF HEART DISEASE OR SUDDEN HEART-RELATED DEATH OF A FAMILY MEMBER BEFORE AGE 50.	
☐	☐	STROKE/TIA	
☐	☐	ASTHMA	(LAST ATTACK DATE)
☐	☐	LUNG/RESPIRATORY DISEASE	
☐	☐	COPD	
☐	☐	EAR/EYES/NOSE/SINUS PROBLEMS	
☐	☐	MUSCULAR/SKELETAL CONDITION/MUSCLE OR BONE ISSUES	
☐	☐	HEAD INJURY/CONCUSSION	
☐	☐	ALTITUDE SICKNESS	
☐	☐	PSYCHIATRIC/PSYCHOLOGICAL OR EMOTIONAL DIFFICULTIES	
☐	☐	BEHAVIORAL/NEUROLOGICAL DISORDERS	
☐	☐	BLOOD DISORDERS/SICKLE CELL DISEASE	
☐	☐	FAINTING SPELLS AND DIZZINESS	
☐	☐	KIDNEY DISEASE	
☐	☐	SEIZURES	(LAST SEIZURE DATE)
☐	☐	ABDOMINAL/STOMACH/DIGESTIVE PROBLEMS	
☐	☐	THYROID DISEASE	
☐	☐	EXCESSIVE FATIGUE	
☐	☐	OBSTRUCTIVE SLEEP APNEA/SLEEP DISORDERS	(CPAP: YES☐ NO☐)
☐	☐	LIST ALL SURGERIES AND HOSPITALIZATIONS	(LAST SURGERY DATE)
☐	☐	LIST ANY OTHER MEDICAL CONDITIONS NOT COVERED ABOVE	

ALLERGIES/MEDICATIONS – ARE YOU ALLERGIC OR DO YOU HAVE ANY ADVERSE REACTION TO ANY OF THE FOLLOWING?

YES	NO	ALLERGIES OR REACTIONS	EXPLAIN
☐	☐	MEDICATION	
☐	☐	FOOD	

YES	NO	ALLERGIES OR REACTIONS	EXPLAIN
☐	☐	PLANTS	
☐	☐	INSECT BITES/STINGS	

List all medications currently used, including any over-the-counter medications.

☐ **CHECK HERE IF NO MEDICATIONS ARE ROUNTINELY TAKEN.** ☐ **IF ADDITIONAL SPACE IS NEEDED, PLEASE INDICATE ON A SEPARATE SHEET AND ATTACH.**

MEDICATION	DOSE	FREQUENCY	REASON

☐ **Yes** ☐ **No** Non-prescription medication administration is authorized with these exceptions: _____

IMMUNIZATION

The following immunizations are recommended. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

Yes	No	Had disease	Immunization	Date(s)	Yes	No	Had Disease	Immunization	Date(s)
☐	☐	☐	Tetanus		☐	☐	☐	Hepatitis A	
☐	☐	☐	Pertussis		☐	☐	☐	Hepatitis B	
☐	☐	☐	Diphtheria		☐	☐	☐	Meningitis	
☐	☐	☐	Measles/mumps/rubella		☐	☐	☐	Influenza	
☐	☐	☐	Polio		☐	☐	☐	Other (i.e., HIB)	
☐	☐	☐	Chicken Pox		☐	☐	☐		

Notes: