



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., its 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.

Address

Applicant's Signature Date of Birth

City/State/Zip

Applicant's Signature Date of Birth

Phone

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



CAMP HEALTH EXAMINATION FORM

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 #: _____

Medications: All medications must be in original pill bottles!

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

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

Medication 2: _____ Dosage: _____ Administer at: ☐ breakfast ☐ lunch
(Check all that apply) ☐ 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
Email: info@expeditionsunlimited.com

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: _____