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.

____
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

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: ______________