

# COLORADO CHALLENGE JUNE 19 - JUNE 25, 2022

## PARTICIPANT CONTACT INFORMATION

(ANY APPLICABLE FIELDS PUT AN "N/A")

### PARTICIPANT PERSONAL INFORMATION

Gender:  MALE  
 FEMALE

Eye color: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

### PARTICIPANT GENERAL INFORMATION

Full name (L, F, Mi): \_\_\_\_\_

Address: \_\_\_\_\_

City, state, zip: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Home phone: \_\_\_\_\_

Church or group: \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

Emergency contact: \_\_\_\_\_

Address: \_\_\_\_\_

City, state, zip: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Home phone: \_\_\_\_\_

Relationship to part.: \_\_\_\_\_

Company name: \_\_\_\_\_

### 2ND EMERGENCY CONTACT

Emergency contact: \_\_\_\_\_

Address: \_\_\_\_\_

City, state, zip: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Home phone: \_\_\_\_\_

Relationship to part.: \_\_\_\_\_

Company name: \_\_\_\_\_

## PARTICIPANT INSURANCE INFORMATION/ CAMP RELEASE ACTIVITIES

(ANY APPLICABLE FIELDS PUT AN "N/A")

### MEMBER INFORMATION

Member's name: \_\_\_\_\_

Relationship to part.: \_\_\_\_\_

Insurance provider: \_\_\_\_\_

Group or employer: \_\_\_\_\_

Policy number: \_\_\_\_\_

Provider phone #: \_\_\_\_\_

### **3** AUTHORIZATION FOR PARTICIPATION IN OTHER CAMP ACTIVITIES

Participant signature: \_\_\_\_\_

Printed name: \_\_\_\_\_

Date (MMDDYY): \_\_\_\_\_

Parent/gu. signature: \_\_\_\_\_

Printed name: \_\_\_\_\_

Date (MMDDYY): \_\_\_\_\_

*I hereby give permission for my child to participate in all camp activities and to go on trips away from the camp premises, whether on foot, on horseback, or by vehicle with the follow exceptions:*

\_\_\_\_\_

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**All participants of Colorado Challenge camp need to fill out the above release sections.**

## PERMISSION FORM AND LIMITED PURPOSE OF ATTORNEY FOR MEDICAL TREATMENT

(ANY APPLICABLE FIELDS PUT AN "N/A")

I hereby grant permission for the above named person to attend Colorado Challenge, to take part in all aspects there, and be bound by the rules set forth by the leaders of Colorado Challenge, Quaker Ridge Camp, and \_\_\_\_\_ (herein after "the Delegation"). I further agree to hold harmless all persons and organizations involved with the camp and further grant permission for Colorado Challenge to use the image or likeness of the above named individual in any photographs, camp videos, website, or other media.

### **Health Care Powers**

The undersigned, in the event of an emergency, hereby appoints the adult leaders of Colorado Challenge, Quaker Ridge Camp, or the Delegation named above, each to act alone, and delegate to each such person the power to consent on my behalf to all emergency or medical treatment except elective surgery, determined necessary by a physician, dentist, or other health care provider licensed to practice under the laws of the state where the services are rendered for the person named above.

The adult leaders of Colorado Challenge, Quaker Ridge Camp, and the Delegation are hereby granted full power to substitute for each adult leader to seek medical care for the above named individual. Specifically authorized leaders include but are not limited to:

Nadene Davis - - Scott Davis - - Larry Money, and

\_\_\_\_\_ Fill in additional leader's name if applicable

\_\_\_\_\_ Fill in additional leader's name if applicable

This authorization is intended to act as authorization for each adult leader of Colorado Challenge, Quaker Ridge Camp, and the Delegation, to each serve as personal representative and authorized recipients under the Health Insurance Portability and Accountability Act of 1996 and its regulations (HIPAA). Each representative shall have the unlimited right to request, access, and receive medical and personal information in any form from any individual or organization covered by HIPAA and its regulations.

This Power of Attorney shall continue until revoked by the undersigned, or for six months after its date, whichever is earlier. Health care providers may rely on this authorization during such six-month period unless otherwise notified.

The undersigned certifies that (s)he has read the above authorization and that (s)he understands the power granted herein.

Participant signature: \_\_\_\_\_

Printed name: \_\_\_\_\_

Date (MMDDYY): \_\_\_\_\_

Parent/gu. signature: \_\_\_\_\_

Printed name: \_\_\_\_\_

Date (MMDDYY): \_\_\_\_\_

Witness signature: \_\_\_\_\_

Printed name: \_\_\_\_\_

Date (MMDDYY): \_\_\_\_\_