

Winter Whiteout 2012

Camper Information/Permission and Release

Group Name: (if applicable) _____

Group Leader's Name: (if applicable) _____

Campers Only

Have you or any of your family ever attended a session here at Taconic before: Yes ___ No ___

Name: _____ Date of Birth: _____ Male ___ Female ___ Grade _____

Street Address: _____ Camper's Email _____

City: _____ State: _____ Zip Code: _____

Father's name: _____ Phone # Home () _____ Cell () _____

Mother's name: _____ Phone # Home () _____ Cell () _____

Father's Email: _____ Mother's Email _____

Home Church (if different from group attending) _____

Permission Statement

I understand and certify that my child's participation in Taconic's Whiteout activities is completely voluntary and I have familiarized myself with the camp's program and activities in which my child will be participating. I recognize that certain hazards and dangers are inherent in the Whiteout programs and particularly, but not limited to activities in the snow, football, paintball, broom hockey, volleyball, and basketball. I acknowledge that although Camp Taconic has taken safety measures to minimize risk, Camp Taconic cannot guarantee that the participants, equipment, premises, and/or activities will be free of hazards, accidents and/or injuries. I further recognize and have instructed my child in the importance of knowing and abiding by Camp Taconic rules, regulations and procedures for the safety of camp participants.

In an emergency, I hereby give permission to the physician or hospital selected by the camp director to hospitalize, secure the proper diagnostic, laboratory and radiological procedures, and to order any necessary medications, injections, anesthesia, intravenous therapy, or surgery for my child as named above.

To be signed by parent or guardian for those under 18

Date

Medical Information:

Date of last Tetanus Shot: _____

Known allergies, medical problems or physical limitations:

Person to contact in case of an emergency (if parents not available): _____

Relationship: _____ Phone # () _____

Insurance Information:

Insurance Company: _____

Policy # _____ Group # _____

Name of Policy Holder: _____

If no insurance, I agree to pay for any necessary treatments _____ (signature)