

2011 – Permission Form for Indian Lake Nazarene Camp

ADULT (Age 18 and up)

Rock Climbing Tower and Zip Line

Telephone Number: 269-649-2281 Fax: 269-649-3745 Email: ExecutiveDir@nazcamp.org

Acknowledgement of Risk and Assumption of Personal Responsibility

I understand that my participation in this adventure course activity may expose me to psychological, physical, and challenging situations.

I understand that although the camp has taken precautions to provide proper organization, supervision, instruction, and equipment it is not possible to guarantee absolute safety.

I understand that I share responsibility for my safety and I accept that responsibility.

I waive any claim that may arise against ILNC and/or its employees as a result of my participation in the Rock Climbing Wall or Zip Line, except those which are the direct result of negligence of ILNC.

I agree to comply with all instructions and directions of ILNC staff during my participation.

Medical Statement

I recognize that challenge course activities such the Rock Climbing Wall and Zip Line can be strenuous ventures requiring me to be in good physical condition. I have the following condition(s).

- | | | |
|--|---|---|
| <input type="checkbox"/> Cardiac Disease | <input type="checkbox"/> Pulmonary Disease | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fainting Spells |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hearing Impairment |
| <input type="checkbox"/> Drug Dependency/Addiction | <input type="checkbox"/> Back/Neck Injury | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Nervous/Mental Disorder | <input type="checkbox"/> Recent Injuries |
| <input type="checkbox"/> Insect Allergies | <input type="checkbox"/> Any Other Health Concern | |

If you checked any condition above, please explain: _____

I hereby certify that I do not suffer from any physical or psychological infirmities or illnesses which would affect my ability to engage in the Rock Climbing Tower or Zip Line activity. I have accepted responsibility for verifying my personal health and any medical history as listed above.

I also understand that there can be no guarantee of safety against risk of unforeseen accident(s). I hereby give my permission to be transported to the nearest medical emergency facility and treated by emergency medical physicians at such facility in the event of such accident.

Name: _____ **Date of Birth:** _____

(Print Clearly)

Telephone No: _____ **Date:** _____

In the event of an accident or emergency: **Contact-Name** _____ **Phone:** _____