



MEDICAL FORM AND LIABILITY RELEASE

Type of Activities: _____ Date of Activities: _____ to _____

Participant's Information (Please print in black or blue ink)

Name: _____ Age: _____ Date of Birth: ____/____/____
First Middle Last

Address: _____ Height: _____ Weight: _____ Gender: M / F

Contact Details: (phone) _____ (email) _____

Emergency Contacts (Parent or Legal Guardian if Participant is under 18)

Name: _____ Relationship: _____ Phone: _____

Alternate Contact: _____ Relationship: _____ Phone: _____

Primary Care Physician: _____ Medical Office Phone: _____

Insurance Carrier: _____ Policy Number: _____

Present Health

ALLERGIES

Bee or Insect Sting Allergies: Yes / No Treatment for Past Stings: Benadryl / Epi-pen / Others _____

Drug Allergies: (List) _____

Food Allergies: (List) _____

Other Allergies: (List) _____

MEDICATIONS:

Important! All Medications MUS be brought in the original container with doctor's instructions.

Activity Restrictions: _____ Date of Last Known Tetanus Shot: (DPT) ____/____/____
Month / Year

Dietary Restrictions: _____ Date of Last Physical Exam: ____/____/____
Month / Year

Physical Handicaps: _____ All Immunizations up to Date: Yes / No

Health History (Please check conditions and describe)

- | | | |
|--|--|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Joint or Muscle Pain |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diarrhea / Constipation | <input type="checkbox"/> Knee Injury or trouble |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Dislocations | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Migraine Headache |
| <input type="checkbox"/> Back pain or injury | <input type="checkbox"/> Emotional Behavior | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Motion Sickness |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Blood Pressure (high/low) | <input type="checkbox"/> Fractures | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Skin Conditions or rashes |

Details:

Name of injuries, illness or disabilities not mentioned, and the year of occurrence:

Hospitalization or surgeries



- | | | |
|---|---|---|
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Sleepwalking |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Sprains or Strains |
| <input type="checkbox"/> Concussion / Head Injury | <input type="checkbox"/> Heat Stroke | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Corrective Lenses (eyes) | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tumor or Growth |
| <input type="checkbox"/> Cramps | <input type="checkbox"/> Hepatitis A, B, or C | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cystitis | <input type="checkbox"/> Hernias | <input type="checkbox"/> Urinary Difficulties |
| <input type="checkbox"/> Dental Appliances | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Venereal Disease |

(list the date, reason, hospital name and location):

MEDICAL FORM AND LIABILITY RELEASE

Medical Authorization And Insurance Coverage

THIS HEALTH INFORMATION IS CORRECT, as far as I know. In the event the emergency contact cannot be reached in an emergency during the program dates noted on this form, I HEREBY GIVE PERMISSION to the physician selected by Bread of Life Asian Ministries International, to secure proper treatment, to order injection, anesthesia, dental care and/or surgery for the participant. I GIVE PERMISSION for Bread of Life Asian Ministries International to provide for the participant a certified First Aid provider to administer First Aid and over the counter medication as needed for illness or injury as well as any medication noted. I AGREE that photocopies or faxes of this provider form are to be considered legally valid and binding for trips off the property. I AGREE to obtain and maintain personal insurance covering the participant in the program with appropriate waiver of subrogation rights to reflect the fact that the participant's personal insurance shall supersede and be used before any insurance coverage that may be provided by Bread of Life Asian Ministries International. In the absence of the aforementioned insurance, I AGREE to pay all costs of rescue and/or medical services as may be incurred by the participant.

Acknowledgement of Risks And Capabilities

I RECOGNIZE that there is a significant element of risk in any sport or activity associated with the outdoors and trust. THESE RISKS MAY INCLUDE but are not limited to falling trees, rocks, or other objects, poisonous plants, reptiles and insects, domesticated and wild animals, crossing steep, uneven loose terrain, exposure to the elements, lightning strikes, fires, streams crossings, open untreated water, flash floods, landslides, depending on the other group members for physical and emotional safety, contact with abrasive or slippery rock, equipment failure or misuse, injury from entanglement with ropes, cables and other equipment, and at times a remote location far from modern medical facilities and rescue assistance. I AM AWARE that certain portions of the program are physically demanding and that the participant may be asked to walk, run, stretch, climb, push, pull and perform rigorous and potentially risky or dangerous physical activities which may double their normal resting heart rate. I VOLUNTARILY AGREE to participate in the program. Realizing that pre-existing medical conditions could affect the participant's ability to participate in the program. I FURTHER AGREE to get a qualified medical opinion if the participant is over 50 years old and/or if I doubt their ability to participate. I AGREE to abide by the activity restrictions and to participate only to the extent that my medical, physical, emotional, or other conditions create no undue risk to myself, other participants, or program staff. I FURTHER ACKNOWLEDGE that exposure to these inherent risks, rigors and dangers may result in but is not limited to separation from the group, bruising, bodily injury, emotional trauma, permanent disability including loss of site in extreme cases death. Knowing these risks and potential consequences, I CERTIFY that the participant is fully capable of participating in the program activities which may include but are not limited to hiking, backpacking, bouldering, rock climbing, rappelling, initiative games, low ropes, high ropes, caving, mountain biking, paintball, horseback riding, fishing, swimming, water sports, canoeing, sailing, powered water craft, white water rafting, archery, batting cage use, individual sports including skateboarding, and team sports, except as noted under activity restrictions.

Assumption of Responsibility

I AGREE to assume full responsibility for the participant's actions and their consequences during their participation in the program, and including without limitation, any injury to the applicant and/or property or any inconvenience resulting there from or from any other circumstance related to such actions. I, the participant, AGREE to follow all the rules and regulations of the said activity which communicated to me verbally by the Bread of Life Asian Ministries International staff.

Covenant of Good Faith

I AGREE that the Bread of Life Asian Ministries International has the right to refuse any participant it judges to be incapable of meeting the rigors and requirements of participating in these activities. I AGREE that any decision made by the staff of Bread of Life Asian Ministries International will be binding upon the participant. The Bread of Life Asian Ministries International reserves the right to dismiss any participant (at their expense) who through their action of in-action, influences or causes an event, which is detrimental to the best interests of themselves or others.

Permission for Participation, Transportation, and Promotion

I GRANT PERMISSION for the participant to engage in all Bread of Life Asian Ministries International activities and to be transported by a Bread of Life Asian Ministries International staff member who is legally licensed driver on all activities sponsored by the Bread of Life Asian Ministries International. I GIVE PERMISSION for Bread of Life Asian Ministries International to use images of the participant taken while at the activity, and quotations from evaluations, letters or interviews relating to the program experience for promotion and commercial purposes.

Waiver of Liability

I HEREBY RELEASE and agree to INDEMNIFY, DEFEND AND HOLD HARMLESS Bread of Life Asian Ministries International, its board of elders, operating board, pastors, officers, employees, guides, and volunteers and each and every land owner, municipality and/or governmental agency upon whose property the activity is conducted, from any and all liability, claims, losses, costs, expenses (including without limitation, attorney fees) or demands (except those arising from the gross negligence or willful misconduct of the aforementioned parties) that I, my heirs, executors, trustees, administrators, assignees, personal or legal representatives and all members of my family, may now have or in the future make against such parties as a result of or related to any injury, loss, death or damage of any kind whatsoever resulting from the participant's participation in this program or from any driving mishap that may occur during the transportation.

Acceptance Signature



Bread of Life Asian Ministries International
@Pinnacle Village

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 (818) 797-4869 bolusa@breadoflifeusa.org
 www.breadoflifeusa.org

I/WE HAVE READ, UNDERSTOOD AND ACCEPTED the terms and conditions stated herein and acknowledge that this agreement shall be effective and binding upon the participation hereafter.

(Please write in ink)

Participant Signature or Legal Guardian *(if under 18):* **X**

Date:

Please Print Name: _____

Please check one: PARENT / GUARDIAN / SELF

OFFICE USE ONLY	
	Y N
Meds.	
Ill/Inj.	
Flu.	
REMARKS:	