

Partners In Adventure Health Form Part 2

Please have the following filled out by a physician:

Name _____
Problem list if any _____
Allergies _____
To my knowledge there is no reason why this person cannot participate in supervised camp activities, including horseback riding, swimming and boating, downhill skiing, snowboarding, ice fishing, etc (All programs are available as adaptive programs for people with disabilities if needed.)
Restrictions _____ _____
Physician's name (please print) _____
Physician's signature _____
Address _____ City _____ State _____ Zip _____
Phone _____ Date _____

If you don't have the information about your camper's aide when you send in these papers, please let us know as soon as possible.

If camper requires an aide in school, an assistant will be required for camp. If you think your child could use a shared aide, we will help match you with another parent of a child. We expect parents to provide assistants who are mature and responsible. Parents must assume the cost of the aide, but there is no cost for the aide to participate with the camper in camp programs. Please provide information about your camper's assistant:

Name of assistant _____
Age of assistant _____

How well does the assistant know your child?

In the event that emergency treatment is required for the aide due to illness or injury while participating in camp, I authorize Partners in Adventure staff to secure medical emergency treatment.

Signature of aide _____ Date _____