Sponsored by: *United Church of God, an International Association*

Challenger Sierra 2024

Health and Insurance Form

PERSONAL INFORMATION (Please type or print clearly in all sections)

Applicant's Name: _____ Sex: ___Male ___Female Birth Date: _____/_____/_____
First M.I. Last

Address: _____ Phone: (_____) _____
Street Address City State Zip

Social Security Number of Participant: _____ - _____ - _____

Emergency Contact: _____ Relationship: _____

Telephone: (_____) _____ (_____) _____ (_____) _____
Primary Secondary Other

Second Emergency Contact: _____ Relationship: _____

Telephone: (_____) _____ (_____) _____ (_____) _____
Primary Secondary Other

MEDICAL / HEALTH HISTORY

Health History—Explain any "yes" answers below

Does/did the participant have:	YES	NO
1. Recent injury, illness or infectious disease?	___	___
2. Mononucleosis in the past 12 months?	___	___
3. Chronic or recurring illness/condition?	___	___
4. Diabetes?	___	___
5. Food allergies?	___	___
6. Allergic to any medications (list below)	___	___
7. Respiratory problems or asthma?	___	___
8. Frequent headaches or migraines?	___	___
9. Ever passed out during or after exercise?	___	___
10. Ever been dizzy or faint during or after exercise?	___	___
11. Ever experienced altitude symptoms?	___	___
12. Ever had seizures?	___	___
13. Ever had chest pain during or after exercise?	___	___

	YES	NO
14. Heart murmur?	___	___
15. High blood pressure?	___	___
16. Deep vein thrombosis?	___	___
17. Blood disorder?	___	___
18. Back injuries or problems?	___	___
19. Joint surgeries?	___	___
20. Sleepwalking?	___	___
21. Eating disorder?	___	___
22. Overweight or underweight?	___	___
23. Emotional or mental difficulties for which professional help was sought?	___	___
24. (Females) Treatment for menstrual cramps?	___	___
25. (Females) Pregnant?	___	___

If you checked "yes" to any of the above, please note the question # and explain, including any continuing medications needed.

Please list all medications (including over-the-counter or other nonprescription drugs) taken routinely. Be sure to bring your medication with you **in the original packaging** that will identify the doctor, the dosage and the frequency of administration:

Medication	Dosage	Frequency	Reason for Taking

Please list all injuries you have had and any surgeries subsequent to the injuries :

Injury	Impact	Surgery	Limitation

Do you have any health issues that *might* hinder you from participating fully in the program as described? ☐ **Yes** ☐ **No**

If yes, please describe in detail (attach note if necessary): _____

_____

_____

ADULT APPLICANT: I certify that to the best of my knowledge that this health history is accurate and complete, that I am in good health and able to participate in this program. I will commit to a training program to prepare for the rigorous nature of the Challenger program. This will include cardio, hiking, and exercises to improve core strength.

Adult applicant signature: _____ Date _____

INSURANCE COVERAGE AND RELEASE

Insurance Company: _____ Policy or Group # _____

Social Security Number of Policyholder or Insurance ID Number: _____ Policyholder Date of Birth: _____

Insurance Phone # (_____) _____ Address: _____

Family Physician: _____ Phone: (_____) _____

Address: _____

Family Dentist/Orthodontist: _____ Phone: (_____) _____

Address: _____

Personal Medical Insurance

While we place a significant emphasis on safety at the Challenger Sierra 2024 programs, accidents may happen and people may get injured. For this reason, we strongly recommend that you carry adequate personal medical insurance. We realize that it is not always affordable. However, paying actual hospital and doctor expenses can easily cost far more. As we review your application, this is an important factor in determining those most suited to participate in the program.

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Supplemental Accident Insurance

We realize that your personal insurance may require you to pay a deductible and co-payments, and possibly other costs. In an effort to help reduce the cost to you personally, the Church has been able to acquire supplemental accident medical coverage for a nominal cost. Though the Church is unable to provide financial assistance beyond what is offered through this insurance, we are happy to include all program participants in this coverage. The extent (amount and period) of accident coverage may vary from year to year. If you are accepted to this program, a copy of the coverage will be supplied upon request.

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Release and Waiver

I have read, fully understand, and agree to comply with all the rules and standards of the project and its staff. I understand and agree with its implications and the stated consequences. I also affirm that the information given this application is true and complete and that I am in good health and able to participate in the expected activities and routine for the project(s) marked on the front. In consideration of being allowed to participate, I hereby release, indemnify, save and hold harmless and covenant not to sue the United Church of God, *an International Association*, its officers, Council of Elders, agents, employees, volunteers and helpers and any other related entity (hereinafter collectively called the "Church") from all actions, claims, demands or suits which are based upon, or result from injuries sustained, arising out of, or in the course of, participation or attendance at camp. This release, however, shall not apply to claims covered by the Church's liability insurance (e.g. for its negligence) , but is applicable to claims not covered by that insurance. *It is strongly recommended that you have your own medical insurance protection* since participants are involved in activities at their own risk.

Signature _____ Date Signed_____

Print Name_____

MEDICAL EXAM / RECOMMENDATION AND RESTRICTIONS

An exam by a medical practitioner is to be done within 6 months of participation in the program. Use the form below or attach a similar practitioner's exam form. Submit your most current exam form for each program session.

Applicant's Name: _____ **Birth Date:** ___/___/_____

I have examined the above-named participant on ___/___/_____(date). BP_____Weight _____Height _____

In my opinion, the above applicant: _____is _____is not able to participate in an active outdoor wilderness / adventure program that involves **strenuous physical activity, such as hiking and carrying up to 25% of their body weight in a backpack**.

The applicant is under the care of a physician for the following conditions _____

_____

_____

Current treatment at the time of this report includes _____

_____

_____

Recommendations and Restrictions for the Challenger Sierra 2024 Program

Treatment to be continued at camp _____

_____

Medications to be administered at the program (name, dosage, frequency) _____

_____

Any medically-prescribed meal plan or dietary restrictions _____

_____

Known allergies _____

_____

Description of any relevant injuries and subsequent limitation or restriction on program activities _____

_____

_____

Additional information for health care staff at the program(use reverse side if necessary):_____

Signature of Licensed Medical Personnel _____

Printed name _____Title _____

Address _____

Phone _____Date _____