



**Accidental Injury, Personal Property Limitation & Acknowledgment of Risk**

My child \_\_\_\_\_ (child’s first & last name) has my permission to participate in camps conducted at Mt. Hood Community College.

I acknowledge that my child’s participation in the following camps: Outdoor Adventure, Rock-climbing, Sports, Dance or Camp Central entails known and unanticipated risks and may involve trips in vehicles and off campus activities. I agree and promise to accept and assume all responsibility. My child’s participation in activities is purely voluntary.

**ACCIDENTAL INJURY**

I understand that any cost for medical expenses incurred as a result of accidental injury while participating in any activity is not covered by any insurance policy of Mt. Hood Community College.

If you wish to provide yourself with coverage, you can call Insurance Benefits LLC at 1.800.644.5165.

**PERSONAL PROPERTY**

I understand that the college shall not be liable for loss, theft, or damage of any personal property, which may be brought off campus.

I understand MHCC Camp Central retains the right to use for publicity and advertising purposes, any photographs of camp participants.

**ACKNOWLEDGEMENT**

By signing this document, I acknowledge that I have read and understand this entire document, and agree to be bound by its terms.

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Parent/guardian (signature) Date

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Parent/guardian (please print) Date

## Medical/Emergency Information

Date: \_\_\_\_\_

Campers Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Other Persons: (list all other persons who may pick up your child and be contacted in an emergency).

1. \_\_\_\_\_ (primary) Phone #: \_\_\_\_\_

2. \_\_\_\_\_ (alternate) Phone #: \_\_\_\_\_

3. \_\_\_\_\_ (alternate) Phone #: \_\_\_\_\_

Allergies (please list all): \_\_\_\_\_

Medications (please see camp instructor/director regarding medications to be given during camp hours):

\_\_\_\_\_

Restricting Conditions: \_\_\_\_\_

\_\_\_\_\_

Primary Physician or Doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_

Other:

\_\_\_\_\_

\_\_\_\_\_

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