Summer Camp Registration Form

Camp Name:_____ Camp Date: _____

Camp Fee: $ _____ (Discounted amount for BRDC Members)

Participant's Full Name: _____ Age: _____ Birth

Date_____/_____/_____ Male _____ Female _____ T-shirt Size: _____

Parent/Guardian: _____

Mailing Address_____

City_____State_____ZIP_____

Phone (_____)_____ Email_____

Parent/Guardian Cell Phone: _____ Parent/Guardian Work Phone: _____

Emergency Contact: _____ Emergency Phone: _____

THIS REGISTRATION IS NOT VALID WITHOUT THE FOLLOWING SIGNATURE:

Guardian Release: I agree that the above named participant may attend the event listed.

Parent/ Guardian Signature: _____ Date: _____

Payment Information:
Payment: ▢ Check (payable to: Blue Ridge Discovery Center, Mail to: 6402 Whitetop Rd., Troutdale, VA 24378)
▢ Paid Online ▢ Scholarship

Sign me up for a BRDC Membership: ▢ Individual $25 ▢ Family $40 ▢Preserver $100

Camp Fee: $_____
Membership: $_____

(BRDC Membership gives you a discount on program fees! Family membership required for discount on youth camps.)

Total Enclosed: $_____

Blue Ridge Discovery Center

Informed Consent, Release Agreement, and Authorization

Participant's Full Name: _____ DOB: _____

Informed Consent, Release Agreement, and Authorization

I understand that participation in BRDC activities involves risk of personal injury, including death, due to physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the activity coordinators. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the codes of conduct.

In case of an emergency involving my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or adult leader. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child along with the transportation of my child, by ambulance if necessary, to the nearest available medical facility. Medical providers are authorized to disclose protected health information to the adult in charge, event medical staff, event management, and/or any physician or health-care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any volunteers or professionals who need to know of medical conditions that may require special consideration in conducting activities.

With appreciation of the dangers and risks associated with programs and activities, on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against Blue Ridge Discovery Center, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity to the extent allowable by Virginia State Law.

I also hereby assign and grant Blue Ridge Discovery Center and their authorized representatives, the right and permission to use and publish the photographic/video/electronic representations and/or sound recordings made of my child at all activities, and I hereby release Blue Ridge Discovery Center, the activity coordinator, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all liability from such use and publication. I further authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographic/video/electronic representations and/or sound recordings without limitation at the discretion of Blue Ridge Discovery Center, and I specifically waive any right to any compensation I may have for any of the foregoing.

Due to the nature of programs and activities, Blue Ridge Discovery Center cannot continually monitor compliance of program participants or any limitation imposed upon them by parents or medical providers. However, so that leaders can be as familiar as possible with any limitations, list any restrictions imposed on a child participant in connection with programs or activities below.

List participant restrictions, if any:_____

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity. I understand the extent & limitations of the insurance coverage as provided by the organization sponsoring the event, and that my medical insurance is primary. I will inform the leaders of the event prior to the event if there is any change in medical circumstances regarding my child between the date signed below and the start of this event. I understand that I am responsible for my child's actions and will be held financially responsible for any damage done by my child and will pay for any and all repairs incurred by such damage. I give consent for my child to go on Blue Ridge Discovery Center authorized field trips away from premises. I give permission for my child to ride in a vehicle used for event trips or participant transport.

Participant's Signature: _____ Date:_____

Parent/Guardian Signature:_____ Date:_____

(if participant is under the age of 18)

Blue Ridge Discovery Center

Participant Medical History

Participant's Full Name: _____ DOB: _____
Health Insurance Co.: _____
Policy #: _____ Group #: _____
Primary Care Physician: _____
Physician Phone #: _____
Date of last Tetanus Shot:_____

Does participant suffer from any medical, physical, emotional, or behavioral conditions which might affect his/her safety while at this event? (eg. claustrophobia, vertigo, asthma, heart conditions, diabetes, epilepsy, etc.)
▢ Yes ▢ No If yes, please specify: _____

Is the participant currently undergoing any form of medical or psychological treatment, including medication?
▢ Yes ▢ No If yes, please specify: _____

Will the participant be bringing any prescription or nonprescription medication to event?
▢ Yes ▢ No If yes, please fill out the following, listing all medications and dosing information.
If additional space is needed, please indicate on a separate sheet and attach.

Medication_____ Dose _____ Frequency _____ Reason _____
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Medication_____ Dose _____ Frequency _____ Reason _____
▢ Yes ▢ No Nonprescription medication administration (ex. Tylenol, Ibuprofen) is authorized with these exceptions:
_____

Is the participant allergic to or have any adverse reactions to any of the following?:

Medication	▢ Yes	▢ No	If yes, please specify: _____
Food	▢ Yes	▢ No	If yes, please specify: _____
Plants	▢ Yes	▢ No	If yes, please specify: _____
Insect bites/ stings	▢ Yes	▢ No	If yes, please specify: _____

List any surgeries or serious injuries in the last two years: _____

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity. I understand the extent and limitations of the insurance coverage as provided by the organization sponsoring the event, and that my medical insurance is primary.

Parent/Guardian Signature:_____ Date: _____
* Participant should be supplied with sufficient medications in the original containers upon attending event. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication unless instructed to do so by your doctor.