Winter Camp Informed Consent and Medical Form

Full name of adult participant or parent: _____

Full name of youth participant (if applicable): _____

Informed Consent, Release Agreement, and Authorization

I understand that Winter Camp is not an activity of Scouting America, the Michigan Crossroads Council or the Order of the Arrow and is not subject to any jurisdiction or oversight from these organizations. It is offered as a volunteer association from Scouting alumni, who may continue to be involved in Scouting, but are freely providing their skills and talents, having served as council and camp administrators and program directors, as well as maintaining certifications in wilderness first aid and food service safety. This association of alumni refers to itself as ***Winter Camp Future Society***, but remains as a social entity without any legal registration.

I further understand that participation in Winter Camp activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. 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 standards of conduct. In case of an emergency involving me or my child, I understand that efforts will be made to contact the individual listed as the emergency contact person. 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 me or my child. Medical providers are authorized to disclose protected health information to the adult in charge and/or any physician or health-care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., 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. With appreciation of the dangers and risks associated with programs and activities, on my own behalf and/or 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 Winter Camp leadership, the activity coordinators, or other organizations associated with any program or activity.

As a volunteer association, Winter Camp participant families are responsible for any medical expenses through their own insurance. There is no secondary coverage.

Participant's signature: _____ Date: _____

Parent signature for youth: _____ Date: _____
(If participant is under the age of 18)

Document updated: 9/29/25

Steve Donohue
176121 Herrick St
Allen Park, MI 48101-3426
(313)919-0106
sdonohue@wintercamp.com

Winter Camp Participant Medical Information

Full name of participant: _____ Date of birth: _____

Cell phone: _____ Gender: ___ Height: _____ Weight (lbs.): _____

Address/City/State/Zip: _____

Health/Accident Insurance Company: _____ Policy No.: _____

Date of most recent physical: _____ Physician name/phone: _____

In case of emergency, notify the person below:

Name: _____ Relationship: _____

Phone: _____ Other phone: _____

Alternate contact name: _____ Alternate's phone: _____

Do any of these currently apply to you or have you ever been treated for any of the following

Yes	No	Condition	Explain
☐	☐	Allergies. Please list:	
☐	☐	Current prescrip ons. List:	
☐	☐	Diabetes	
☐	☐	Hypertension (high blood pressure)	
☐	☐	Congenital heart disease/heart a ack/chest pain (angina)/heart murmur/coronary artery disease	
☐	☐	Family history of heart disease or any sudden heart-related death of a family member before age 50.	
☐	☐	Stroke/TIA	
☐	☐	Asthma/reac ve airway disease	
☐	☐	Lung/respiratory disease	
☐	☐	COPD	
☐	☐	Ear/eyes/nose/sinus problems	
☐	☐	Muscular/skeletal condi on/muscle or bone issues	
☐	☐	Head injury/concussion/TBI	
☐	☐	Psychiatric/psychological or emo onal difficul es	
☐	☐	Neurological/behavioral disorders	
☐	☐	Blood disorders/sickle cell disease	
☐	☐	Fain ng spells and dizziness	
☐	☐	Kidney disease	
☐	☐	Seizures or epilepsy	
☐	☐	Abdominal/stomach/diges ve issues	
☐	☐	Thyroid disease	
☐	☐	Skin issues	
☐	☐	Obstruc ve sleep apnea/sleep disorders	

Any other important medical informa on or limita ons: