



Lutheran Outdoor Ministries

502 Beltrami Ave NW #3
PO Box 1187
Bemidji, MN 56619
218-751-4208
Fax 218-751-1453
pathways@pathwaysbiblecamps.com

Camp Emmaus
218-564-4766

Lake of the Woods
Bible Camp
218-634-2200

Camp Minne-Wa-Kan
218-335-6159

Pathways is an
Outdoor Ministry of the
Evangelical Lutheran
Church of America.

Dear Challenge Course participant,

We are excited to have you visit our challenge course! You must fill out both of the attached forms. **Even if you are just planning on observing and not participating you still need to fill out both forms!** New forms need to be filled out each time you return to use the course.

Please fill out the appropriate forms. Youth up to age 18 need to fill out a youth health history form and an assumption of risk form. Both require a parent/guardian signature. Adults ages 18 and up need to fill out an adult health history form and an assumption of risk form. All forms are available online at the address below or by calling the Pathways office. If you do not have the paperwork completed, you will not be able to participate on the course.

If you have any questions about these forms or the challenge course program, please contact Korey at 218-760-4212 or korey@pathwaysbiblecamps.com.

See you soon!

Korey Breutzmann
High Adventure and Retreat Director

These forms were printed from
<http://www.pathwaysbiblecamps.com/forms.asp>.

PATHWAYS INC. CHALLENGE COURSE ADULT HEALTH HISTORY

Health information on this form is held confidential unless there is a medical emergency.

Name _____ Group Name: _____
Address _____ Date Attending _____
City _____ State _____ Zip Code _____
Birthdate _____ Sex _____ Home Phone _____ Work Phone _____
Emergency Contact (name and relationship) _____
Home Phone _____ Work Phone _____

INSURANCE COMPANY _____	POLICY NUMBER _____
POLICY HOLDER _____	
IF YOU DO NOT HAVE INSURANCE, PROVIDE YOUR SS# _____	
FAMILY DOCTOR _____	CLINIC/CITY _____
PHONE NUMBER _____	

Are you younger than 18 years old? YES NO

If YES, you need to fill out a YOUTH health history form. You can get one by calling 218-751-4208.

Do you require an inhaler for asthma attacks? YES NO

If YES, it is your responsibility to make sure that your prescribed inhaler is readily available during the program.

Do you have any known allergies? YES NO

If YES, it is your responsibility to make sure that you have food or prescribed medication readily available during the program.

Do you have diabetes? YES NO

If YES, it is your responsibility to make sure that you have food or prescribed medication readily available during the program.

Do you have a history of seizures? YES NO

If YES, do you want an ambulance called if you experience a seizure while participating in this program? YES NO

People with the following medical conditions should consult a physician prior to attending the program.

1. If you have a **history of heart problems or high blood pressure**, you are at risk if you physically participate in this program. Due to the types of physical demands inherent to the activities, you may be jeopardizing your health and well being if you choose to fully participate.
2. If you are **pregnant**, you and your unborn child are at risk if you participate physically in this program. Unintentional impacts to your abdomen can occur during many of the activities that involve physical contact.
3. If you are **recovering from broken bones, dislocated joints, sprains, strains, back or neck injuries**, you are risking re-injury if you participate physically in this program.
4. If you have **an enlarged organ, are a transplant recipient, or have Downs Syndrome**, you are risking injury to the weakened areas of your body.

Participating in this program may involve bending, twisting, lifting, running, jumping, climbing, increased heart or breath rates, and physical contact with others. Unexpected strains or jolts to your body can occur.

Do you have any concerns that might limit your participation in physical activity? YES NO

If YES, please explain: _____

Pathways recommends that you do not physically participate in activities that you think might put you at risk. If you are concerned, your facilitator can provide you with a less physical way to stay involved.

Do you anticipate needing physical assistance from us during your participation? YES NO

If YES, what can we do to assist you? _____

Pathways, Inc.
Assumption of Risk, Medical Authorization, and Publicity Consent Form

By signing this release form I agree to release and hold harmless Pathways Inc., its agents, employees, facilitators, and others, (hereby referred to as "Pathways, Inc.") for any damage or injuries, physical or mental, which I might incur as a result of my voluntary decision to participate in all facets of a Pathways, Inc. program, which may or may not include the Challenge Course program.

If I do voluntarily choose to participate in the program, I recognize that there is a significant element of risk in any adventure, sport, or activity associated with the outdoors. Knowing the inherent risks, dangers, and rigors involved in the activities, I certify that I am fully capable of participating in the activities. I understand that Pathways, Inc. has the right to deny participation if there are any safety concerns.

I assume full responsibility for myself for bodily injury, sickness, disease, death, loss, or damage, and expenses thereof, as a result of my negligence, or other risks, including but not limited to those caused by the Challenge Course, the terrain, the weather, my athletic and physical condition, and other participants.

By signing this release form, I agree that if I do sustain any physical injury or mental damage of any nature as result of my voluntary decision to participate in the Pathways, Inc. program, I voluntarily agree to hold harmless and release the above named parties from any liability therefore and that this release is binding on my heirs and assigns. I agree to accept financial responsibility for any medical expenses and/or loss of income not covered by my insurance policy. In the event of an emergency, I authorize the Pathways, Inc. staff to seek emergency medical treatment.

By signing below I authorize Pathways, Inc. to use any photos or video taken during the visit to Pathways, Inc. in publicity materials for Pathways, Inc.

I acknowledge that I have been given the opportunity to ask questions regarding any aspect of this release form and by signing in the space provided below I do acknowledge that I have read completely and fully understand all aspects of this release form and agree to its terms in its entirety.

Print Participant Name

Date of Program

Participant Signature

Date

Signature of parent or guardian (if under 18)

Date

Print name of parent or guardian

Telephone

Address of participant