YOUNG LIFE OF CANADA – ROCKRIDGE CANYON

INFORMED CONSENT AND HEALTH INFORMATION

*Guests **MUST** **complete all spaces** and **sign this form** prior to participation in any activities at RockRidge Canyon.*
Guests under the age of 19 must have this form signed by a parent or legal guardian.

LAST NAME	**RETREAT DATES**
First Name	**Home Phone**
Mailing Address	**Mobile Phone**
City	**Email Address**
Province	**Emergency Contact Name**
Postal Code	Emergency Cont. Phone #
Children's Names	

CONSENT- Read thoroughly and initial before signing

_____ **MEDICAL TREATMENT**: I hereby give permission to the qualified practitioner appointed by RockRidge Canyon (RRC) to provide medical treatment within their scope of practice. I also agree to be transported to a local hospital in a medical emergency in the event that I am not able to give verbal consent.

_____ **COVID-19 SCREENING PROTOCOLS**: I acknowledge that myself and my family have not travelled outside of the country in the previous 14 days.

I acknowledge that myself and members of my family do not have any symptoms of Covid-19 (including, but not limited to fever, sore throat, coughing, aches, respiratory problems, fatigue, diarrhea, loss of taste or smell, chest pain, rash on skin, discoloration of fingers or toes, headache). If this changes, I will inform RockRidge Canyon and go to the nearest hospital. Furthermore, if myself or anyone in my family confirm that they have contracted Covid-19, I will notify RRC.

I acknowledge that myself and members of my family have not had contact with anyone who has tested Covid-19 positive in the previous 14 days.

Covid-19 has been declared a worldwide pandemic by the World Health Organization and is extremely contagious. While RockRidge Canyon and Young Life have implemented protocols to keep everyone safe, we cannot guarantee that you or your family will not become infected.

I will not hold Young Life and RockRidge Canyon liable for any Covid-19 infection that may occur before, during, or after my visit at RockRidge Canyon.

_____ **PROMOTIONAL**: I give permission to RRC or its designate to send information to my email and also to take and use photos, videos or any other recording of me or my named minor for use in promotional materials or camp videos.

_____ **HEALTH COVERAGE**: I agree to provide RRC with evidence of current medical coverage under BC Medical or equivalent. I understand I may be billed for medical expenses not covered by my Provincial Health Plan, my extended medical coverage, or my personal insurance plan. If they do not completely cover my medical expenses, Young Life's accidental coverage will pay for additional expenses up to a limit of $4,000.00 USD for dental and $20,000.00 USD for other injuries from Young Life activities (not sickness).

_____ **LIABILITY**: I understand RRC has taken certain safety precautions but that by my participation in activities, I understand there are inherent risks based on my involvement and I choose to accept any risk of personal injury. I also understand RRC cannot guarantee a food-allergy-free environment. I am hereby informed that possible illness or injury may result due to exposure to allergens.

_____ **JURISDICTION**: I understand any and all actions that may arise from this agreement or the use of RRC will be governed by the laws of British Columbia, Canada and I consent to the exclusive jurisdiction of the courts in British Columbia, Canada.

_____ **BEHAVIOUR AND DISMISSAL**: The Director or designate reserves the right to dismiss a guest without refund who, in his/her opinion, is a hazard to the safety rights of others or who appears to have rejected the reasonable controls of the property. I certify I have no knowledge of any physical or mental impairment that would be affected by participation in the RRC program. I hereby give permission to the Director or designate of RRC to search belongings or personal affects for prohibited items if suspected. I agree to reimburse RRC for damage or defacement of property attributable to my activity at camp.

_____ **LOST ITEMS**: RRC is not responsible for personal items which are lost, stolen or damaged.

By signing below, I accept that I am giving informed consent for myself and my immediate family members as listed above and understand that there are inherent risks in any and all aspects of participation. I save and hold harmless the Directors, Officers, Volunteers, Employees of RockRidge Canyon, Young Life of Canada and any or all of their affiliates from any and all actions, causes of action, claims and demands resulting from any loss, injury or damage to person or property which has arisen or may arise from any and all use of RRC including any programs, travel, activities, or otherwise.

By signing below, I am verifying I have carefully read and understand the contents of this informed consent and health form and have been given the opportunity to ask questions regarding the above waiver/agreement and my questions been fully answered. The parents/guardians submitting this form on behalf of a minor are those having legal custody of the minor. If a custodial order is in place, this will be fully communicated to RRC including a photocopy of the section of any court order referring to visitation rights. This consent is also intended to include all claims of my family members, estate, heirs, personal representatives or assigns.

➔

Signature _____ **Date** _____

HEALTH CARE INFORMATION FOR MEDICAL & DIETARY USE PAGE 2

(1) **This section is to be completed by every adult guest.** It is the responsibility of the guest, parent, or guardian to notify RockRidge Canyon, in writing, if any new medical issues or conditions arise prior to arrival (e.g. exposure to a communicable disease, etc.)

FULL NAME	**RETREAT DATES**
Date of Birth (dd/mm/yy)	**Medical Service Plan Prov. Health Care #**
Family Physician	Clinic Phone

Special Dietary Requests
(vegan, vegetarian, gluten free, dairy free)

List all known allergies including dietary
(give details and treatment, if applicable)

(2) **Family members under the age of 19**
Note: For more than three children in attendance, complete an additional second page.

1ST CHILD FULL NAME

Date of Birth (dd/mm/yy)	**Medical Service Plan Prov. Health Care #**
Family Physician	Clinic Phone

Special Dietary Requests
(vegan, vegetarian, gluten free, dairy free)

List all known allergies including dietary
(give details and treatment, if applicable)

2nd CHILD FULL NAME

Date of Birth (dd/mm/yy)	**Medical Service Plan Prov. Health Care #**
Family Physician	Clinic Phone

Special Dietary Requests
(vegan, vegetarian, gluten free, dairy free)

List all known allergies including dietary
(give details and treatment, if applicable)

3rd CHILD FULL NAME

Date of Birth (dd/mm/yy)	**Medical Service Plan Prov. Health Care #**
Family Physician	Clinic Phone

Special Dietary Requests
(vegan, vegetarian, gluten free, dairy free)

List all known allergies including dietary
(give details and treatment, if applicable)