



# Table in the Wilderness Camper Registration Form

Register only one camper per form. *Photocopy as many as you need.*

Camper Name: \_\_\_\_\_ E-mail \_\_\_\_\_  
Last First

Permanent Address: \_\_\_\_\_  
Street/ P.O. Box City State Zip Code

Home phone: (\_\_\_\_) \_\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: \_\_\_\_\_

Last year of school completed: \_\_\_\_\_ Dates of Attendance at TWM: \_\_\_\_\_

Name of Parent or Guardian \_\_\_\_\_ Roommate preference (cannot guarantee) \_\_\_\_\_

Person to notify in case of emergency: \_\_\_\_\_  
Name

Relationship \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

T-Shirt sizes (**If Applicable**): Child M \_\_\_\_\_ Adult S \_\_\_\_\_ Adult M \_\_\_\_\_ Adult L \_\_\_\_\_ Adult XL \_\_\_\_\_

- Make checks payable to **Table in the Wilderness Ministries.**
- \$20 deposit must be sent in with registration to hold your spot and counts toward your final bill
- Check list to fill out.
  1. Registration form
  2. Deposit or whole payment
  3. Medical Release form
  4. Camper Acknowledgement of Risks

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## Office Use only

Total Fee \$ \_\_\_\_\_  
\$ \_\_\_\_\_  
Amt pd \$ \_\_\_\_\_  
Bal due \$ \_\_\_\_\_

Tent Assignment \_\_\_\_\_  
Forms received:  
Registration \_\_\_\_\_  
Med Release form \_\_\_\_\_  
Camper Ack. Risks \_\_\_\_\_

## NOTES:



# Camper's Acknowledgment of Risk

There are significant elements of risk in any adventure, sport, activity or training associated with trekking, hiking, mountaineering, walking on glaciated terrain or surfaces (referred to herein as "activity"), and the use of any equipment. In consideration of the services of TABLE IN THE WILDERNESS MINISTRIES, their officers, agents, and employees, and all other persons or entities associated with this business (herein collectively referred to as the "concessionaire"), I agree as follows: Although the concessionaire has taken reasonable steps to provide you with appropriate equipment and/or skilled guides so you can enjoy an activity for which you may not be skilled, we wish to remind you that this activity still has risks. Certain risks cannot be eliminated without destroying the unique character of the activity. The same elements that contribute to the unique character of the activity can be causes of loss or damage to your equipment, or accidental injury, illness or in extreme cases, permanent trauma or death. **We do not want to frighten you or reduce your enthusiasm for this activity**, but we do think it is important for you to know in advance what to expect, and to be informed of the inherent risks. The following describes some, but not all, of those risks.

- Falls
- Heat related illnesses including heat exhaustion and heat stroke
- River crossings, fording, or travel including travel to or from the activity
- Risk associated with crossing, climbing, or down climbing rock snow, and/or ice.
- Impaired sense of balance, physical coordination, and ability to follow instructions, and the actions of other climbers
- Cold weather related injuries including hypothermia, frostbit, and frostbite, which may result in loss of limbs, digits, and/or permanent scarring
- Altitude related sicknesses including acute mountain sickness, pulmonary edema, cerebral edema and or retinal hemorrhage
- Avalanche, rock fall, crevasse fall, inclement weather, high winds, and severe cold
- Equipment failure
- Accidents or illnesses occurring in remote places where there are no available medical facilities

I am aware that this activity entails risks of injury or death to myself. I understand the description of these risks is not complete and that other unknown or unanticipated risks may result in injury, illness, or death. I agree to assume responsibility for the risks identified herein and those risks not specifically identified. My participation in this activity is purely voluntary. No one is forcing me to participate, and I elect to participate in spite of these risks. I possess at least the following qualifications, which I understand are prerequisites to participate in this activity:

I am (we are) physically and mentally capable of participating in this activity and/or using the equipment

I am (we are) safety conscious and acknowledge that wearing a UIAA approved helmet may be a basic safety precaution with respect to preventing head injury while rock climbing, rock face climbing, or rappelling

I acknowledge that if, during the activity, I/we experience fatigue, chill and/or dizziness, my/our reaction time may be diminished and the risk of accident increased I certify that I am (we are) fully capable of participating in this activity. Therefore, I assume full responsibility for myself, including any minor children for which I am responsible, for bodily injury, accidents, illness, death, loss of personal property, and expenses thereof as a result of those inherent risks and dangers, and of my/our negligence in participating in this activity.

I have read, understood, and accepted the terms and conditions stated herein and acknowledge that this agreement shall be binding upon myself, my heirs, assigns, personal representative, and estate, and for all members of my family including any minors accompanying me.

Participant's Signature

Date

Guardian/Parent's Signature(if under 21)

Date

## Media Release

I understand that Table in the Wilderness Camp reserves the right to use any audio, video and/or photographs of any camper or guest participating in any Table-facilitated event for promotional or marketing purposes.

Participant's Signature

Date

Parent/Guardian Signature (if under 21)

Date

Please return to Table in the Wilderness  
P.O. Box 151 Centennial, WY 82055 – Phone - TWM Lodge (307) 745-3055  
[twmcamp@gmail.com](mailto:twmcamp@gmail.com), [www.twmcamp.net](http://www.twmcamp.net)



# Medical Form/1

Please take the time to carefully and neatly complete all sections of this form. We must have a medical form on file for every camper by the first day of camp. Please include both pages.

Name \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
 Grade entering \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Eye Color \_\_\_\_\_  
 Wears Glasses Yes \_\_\_\_\_ No \_\_\_\_\_ Wears Contact Lenses Yes \_\_\_\_\_ No \_\_\_\_\_  
 Mailing Address \_\_\_\_\_  
 City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip/Postal \_\_\_\_\_  
 Parent/Guardian Name(s) \_\_\_\_\_  
 Best way to Contact: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

## Emergency contact Information

In the event of an emergency we will try to contact the parent/guardian listed above. If the parent or guardian cannot be contacted, list below (in order of priority) who we should try to contact.

**These contacts should be individuals other than the Parent/Guardian listed above.**

<u>Contact #1</u>	<u>Contact #2</u>	<u>Contact #3</u>
Name _____	Name _____	Name _____
Home Phone:(____) _____	Home Phone:(____) _____	Home Phone:(____) _____
Work Phone:(____) _____	Work Phone:(____) _____	Work Phone:(____) _____
Cell Phone: (____) _____	Cell Phone: (____) _____	Cell Phone: (____) _____
Relationship: _____	Relationship: _____	Relationship: _____

## Medical/Health Insurance Information

TWM supplemental medical insurance pays only medical expenses caused by an accident up to \$5,000 that is not covered by your family plan. That means that medical expenses caused by doctor's visits for such things as flu, colds, or appendicitis are the responsibility of the participant and/or their family, and are not covered by TWM.

Do you have health insurance? Yes \_\_\_\_\_ No \_\_\_\_\_ **Please include of photocopy of card**  
 Health Insurance Provider \_\_\_\_\_ Policy Number \_\_\_\_\_  
 Family Doctor \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
 Clinic Name \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**\*\*\*A photocopy of your Insurance card MUST accompany this medical form\*\*\***

## Medical History

Medication Allergies \_\_\_\_\_  
 Food Allergies \_\_\_\_\_  
 Environmental Allergies \_\_\_\_\_  
 No Known Allergies \_\_\_\_\_ Vaccinations: \_\_\_\_\_ H1N1 \_\_\_\_\_ Influenza \_\_\_\_\_ Other \_\_\_\_\_

Please check on the list below all conditions that the participant has a tendency towards:

____ Asthma	____ insomnia	____ hay fever	____ physical handicap
____ Bed wetting	____ nervousness	____ homesickness	____ Car Sickness
____ Earaches	____ seizure disorder	____ convulsions	____ Other (Please List)
____ Diabetes	____ hyperactivity	____ sleepwalking	
____ Epilepsy	____ heart condition	____ stomach problem	

# Medical Form/2

List any recent illnesses or accidents, as well as the dates and current status of the illness or accident:

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## Medications

Does the participant take any medications on a regular basis? Yes \_\_\_\_\_ No \_\_\_\_\_  
Has his/her medication changed in the last 14-30 days? Yes \_\_\_\_\_ No \_\_\_\_\_  
Has his/her dosage changed in the last 14-30 days? Yes \_\_\_\_\_ No \_\_\_\_\_  
Will the participant need any medications while he/she is at camp? Yes \_\_\_\_\_ No \_\_\_\_\_

If you checked yes, please list all the medications and time of day they need to be taken. Please note that all Prescription medications must arrive at TWM in their original containers, and will be administered per the Doctor's Prescription.

Medications	Dose	Directions (ex. 2xaday, etc)	Time (s)
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In addition to prescribed medications, please check all of the following over-the-counter medications that the participant is authorized to receive while at camp. Please note that only medications that have been authorized will be administered while the participant is at camp.

\_\_\_\_\_ Tylenol                      \_\_\_\_\_ Advil                      \_\_\_\_\_ Stomach Antacid                      \_\_\_\_\_ Decongestant  
\_\_\_\_\_ Antihistamine                      \_\_\_\_\_ Other OTC meds \_\_\_\_\_

## Dietary Restrictions

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## Activity Restrictions

Please indicate any restrictions for your child.

\_\_\_\_\_ Swimming Restrictions: \_\_\_\_\_

\_\_\_\_\_ Activity Restrictions: \_\_\_\_\_

## Parental Consent

I certify that the above information is accurate. In the event of an emergency, I hereby give permission for the participant to receive medical treatment at the nearest hospital or clinic. I expect to be contacted as soon as possible, should this happen. If I choose not to provide TWM with the necessary information, such as serious medical conditions or allergies, I will not hold TWM and/or camp personnel liable for any injury or death that could occur to the participant as a result of the lack of this information.

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature (if under 19)

\_\_\_\_\_  
Date

**Please return application to Table in the Wilderness**  
**P.O. Box 151, Centennial, WY 82055 Phone -TWM Lodge (307) 745-3055**  
**twmcamp@gmail.com, www.twmcamp.net**