

# Challenger

## Health and Insurance Form

### PERSONAL INFORMATION (Please type or print clearly in all sections)

Applicant's Name: \_\_\_\_\_ Sex: ☐ Male ☐ Female Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
First M.I. Last

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Street Address City State Zip

Social Security Number of Participant: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Primary Secondary Other

Second Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Primary Secondary Other

### MEDICAL / HEALTH HISTORY

**Health History**—Explain any “yes” answers below

Does/did the participant have:	YES	NO		YES	NO
1. Recent injury, illness or infectious disease?	___	___	14. Heart murmur?	___	___
2. Mononucleosis in the past 12 months?	___	___	15. High blood pressure?	___	___
3. Chronic or recurring illness/condition?	___	___	16. Deep vein thrombosis?	___	___
4. Diabetes?	___	___	17. Blood disorder?	___	___
5. Food allergies?	___	___	18. Back injuries or problems?	___	___
6. Allergic to any medications (list below)	___	___	19. Joint surgeries?	___	___
7. Respiratory problems or asthma?	___	___	20. Sleepwalking?	___	___
8. Frequent headaches or migraines?	___	___	21. Eating disorder?	___	___
9. Ever passed out during or after exercise?	___	___	22. Overweight or underweight?	___	___
10. Ever been dizzy or faint during or after exercise?	___	___	23. Emotional or mental difficulties for which professional help was sought?	___	___
11. Ever experienced altitude symptoms?	___	___	24. (Females) Treatment for menstrual cramps?	___	___
12. Ever had seizures?	___	___	25. (Females) Pregnant?	___	___
13. Ever had chest pain during or after exercise?	___	___			

If you checked “yes” to any of the above, please note the question # and explain, including any continuing medications needed.

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Please list all medications (including over-the-counter or other nonprescription drugs) taken routinely. Be sure to bring your medication with you **in the original packaging** that will identify the doctor, the dosage and the frequency of administration:

Medication	Dosage	Frequency	Reason for Taking

Please list all injuries you have had and any surgeries subsequent to the injuries :

Injury	Impact	Surgery	Limitation

Do you have any health issues that *might* hinder you from participating fully in the program as described? \_\_ Yes \_\_ No

If yes, please describe in detail (attach note if necessary): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**ADULT APPLICANT:** I certify that to the best of my knowledge that this health history is accurate and complete, that I am in good health and able to participate in this program. I will commit to a training program to prepare for the rigorous nature of the Challenger program. This will include cardio, hiking and exercises to improve core strength.

**Adult applicant signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

## INSURANCE COVERAGE AND RELEASE

Insurance Company: \_\_\_\_\_ Policy or Group # \_\_\_\_\_

Social Security Number of Policyholder or Insurance ID Number: \_\_\_\_\_ Policyholder Date of Birth: \_\_\_\_\_

Insurance Phone # (\_\_\_\_\_) \_\_\_\_\_ Address: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Family Dentist/Orthodontist: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

### Personal Medical Insurance

While we place a significant emphasis on safety at the Challenger programs, accidents may happen and people may get injured. For this reason, we strongly recommend that you carry adequate personal medical insurance. We realize that it is not always affordable. However, paying actual hospital and doctor expenses can easily cost far more. As we review your application, this is an important factor in determining those most suited to participate in the program.

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### Supplemental Accident Insurance

We realize that your personal insurance may require you to pay a deductible and co-payments, and possibly other costs. In an effort to help reduce the cost to you personally, the Church has been able to acquire supplemental accident medical coverage for a nominal cost. Though the Church is unable to provide financial assistance beyond what is offered through this insurance, we are happy to include all program participants in this coverage. The extent (amount and period) of accident coverage may vary from year to year. If you are accepted to this program, a copy of the coverage will be supplied upon request.

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### Release and Waiver

I have read, fully understand, and agree to comply with all the rules and standards of the project and its staff. I understand and agree with its implications and the stated consequences. I also affirm that the information given this application is true and complete and that I am in good health and able to participate in the expected activities and routine for the project(s) marked on the front. In consideration of being allowed to participate, I hereby release, indemnify, save and hold harmless and covenant not to sue the United Church of God, *an International Association*, its officers, Council of Elders, agents, employees, volunteers and helpers and any other related entity (hereinafter collectively called the "Church") from all actions, claims, demands or suits which are based upon, or result from injuries sustained, arising out of, or in the course of, participation or attendance at camp. This release, however, shall not apply to claims covered by the Church's liability insurance (e.g. for its negligence), but is applicable to claims not covered by that insurance. *It is strongly recommended that you have your own medical insurance protection* since participants are involved in activities at their own risk.

Signature \_\_\_\_\_

Date Signed \_\_\_\_\_

Print Name \_\_\_\_\_