



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.

Form with fields: Last Name, Group Name, First Name, Group Event Date(s), Mailing Address, Phone, City, Email Address, Province, Emergency Contact Name, Postal Code, Emergency Number, Children's Name

FAMILY INFORMED 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 acknowledge that COVID-19 and other infectious diseases remain a potential risk of exposure due to camping and other congregate living situations, and I further acknowledge and agree that a) RRC will follow current public health protocols...

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.

LOST ITEMS: RRC is not responsible for personal items which are lost, stolen or damaged. Shipping of found items would be at my own expense.

By signing below, I accept that I am giving informed consent 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, you are verifying that you have carefully read and understand the contents of this informed consent and health form. 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.

LIABILITY: I understand RRC has undertaken to ensure the property and recreational activities are as safe as possible. 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.

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.

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. I agree to remove myself if permission is not granted.

Signature

Date

(1) **This section is to be completed by every adult guest.**

Full Name:	
Date of Birth: <i>DD/MM/YY</i>	Medical Service Plan Prov. Health Care #:

(2) Family members under the age of 19

Note: For more than four children in attendance, complete an additional second page.

1st Child Full Name:	
Date of Birth: <i>DD/MM/YY</i>	Medical Service Plan Prov. Health Care #:

2nd Child Full Name:	
Date of Birth: <i>DD/MM/YY</i>	Medical Service Plan Prov. Health Care #:

3rd Child Full Name:	
Date of Birth: <i>DD/MM/YY</i>	Medical Service Plan Prov. Health Care #:

4th Child Full Name:	
Date of Birth: <i>DD/MM/YY</i>	Medical Service Plan Prov. Health Care #: