



Sept. 1<sup>st</sup> – May 31<sup>st</sup>

- Administrative Office -

2318 6th Street, North  
Sheboygan, Wisconsin 53083 USA

608-787-8304

Internationally: 001-608-787-8304

June 1<sup>st</sup> – August 31<sup>st</sup>

- WeHaKee Camp for Girls -

N8104 Barker Lake Road  
Winter, Wisconsin 54896 USA

715-266-3263

Internationally: 001-715-266-3263

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# Group Camp Adult Acceptance & Release Form

Please complete, sign, and return this page to the WeHaKee Camp for Girls Administrative Office no later than July 15<sup>th</sup>.

Attending:  Family Camp  Mother/Daughter Camp  100<sup>th</sup> Anniversary Celebration Attending With: \_\_\_\_\_

Participant Legal Name: (First, Middle, & Last) \_\_\_\_\_

Sex Assigned At Birth:  Female  Male Birthdate: (Month/Day/Year) \_\_\_\_\_ Age At Arrival At Camp: \_\_\_\_\_

## Participant Information - Please print clearly

Participant Home Address: \_\_\_\_\_  
Street City/State (Province)/Zip (Postal) Code Country

Preferred Phone: (1) \_\_\_\_\_ Preferred Phone: (2) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

## Please initial each box acknowledging your informed release & provide supplemental information as requested:

\_\_\_\_\_ I have read the WeHaKee Group Camp Guide and understand and agree to abide by all of the policies as they relate to my participation at Camp WeHaKee and in all camp programs.

\_\_\_\_\_ During my attendance at Camp WeHaKee:

I have reviewed the camp program and activities and I confirm that I can participate without restrictions

I have reviewed the camp program and activities and I confirm that I can participate with the following restrictions  
(Please describe below. Attach a separate sheet if necessary):

\_\_\_\_\_ My allergy status is as follows:

I have no known allergies

I have a food allergy (Please describe below. Attach a separate sheet if necessary):

I have a medicine allergy (Please describe below. Attach a separate sheet if necessary):

I have an environmental allergy (Such as insect stings, hay fever, etc. Please describe below. Attach a separate sheet if necessary):

\_\_\_\_\_ My dietary and nutritional status is as follows:

I consume a regular diet

I consume a regular vegetarian diet

I have the following special food needs (Please describe below. Attach a separate sheet if necessary):



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Please complete, sign, and return this page to the WeHaKee Camp for Girls Administrative Office no later than July 15<sup>th</sup>.

\_\_\_\_\_ My medical insurance status is as follows:

YES, I am covered by medical/hospital insurance

Insurance Company/Phone: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber Number: \_\_\_\_\_

NO, I am NOT covered by medical/hospital insurance

\_\_\_\_\_ I provide my consent for representatives of WeHaKee Camp for Girls to take and maintain images (photos, videos, etc.) of myself while a participant at Camp WeHaKee and Camp WeHaKee related events/activities, and that such images can be used for promotional purposes by Camp WeHaKee including but not limited to brochures, website, promotional videos, social media and other broadcast media as well as other Camp WeHaKee related media. I understand that images of myself used in Camp WeHaKee promotional materials will never be identified by full name. I also understand that Camp WeHaKee is not responsible for images of participants participating in WeHaKee activities, events, etc. that may be posted on social media or other broadcast means by others not related to or authorized by Camp WeHaKee.

\_\_\_\_\_ I understand that WeHaKee Camp policy prohibits me from posting photos, video, logos or other images of WeHaKee or its participants on websites, social media sites, or other broadcast electronic means.

\_\_\_\_\_ I am the participant listed above. I release Camp WeHaKee from any form of liability as I have given permission to participate. I also understand that Camp WeHaKee, its staff and agents will not be held liable for any loss, including but not limited to injury or death.

\_\_\_\_\_ I am currently vaccinated in accordance with the Centers for Disease Control and Prevention’s most recent Recommended Adult Immunization Schedule for ages 19 years or older (including the following vaccinations for diphtheria, tetanus, pertussis, mumps, measles, rubella, COVID-19, PCV, Hepatitis B & A, Varicella/chicken pox, meningococcal meningitis).

YES  NO\* *If NO to any of these vaccinations, please contact our Administrative Office as soon as possible.*

I, (Participant name) \_\_\_\_\_ agree to be a positive and respectful member of the WeHaKee community throughout my session at Camp WeHaKee. In addition, I have reviewed the WeHaKee Group Camp Guide and understand and accept what is expected of me as a member of the WeHaKee Camp community. I specifically understand what behaviors are acceptable and unacceptable at Camp WeHaKee as discussed in the Expectations at Camp section of the guide. Additionally, I agree not to post photos, video, logos, or other images of Camp WeHaKee or its participants on internet sites or other broadcast electronic means of any kind.

I confirm that the health information I have provided is correct and accurately reflects the health status of myself, the participant to whom it pertains. I attest that all of my immunizations are up to date. I attest that I am able to participate in all camp activities except as noted by me above. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of this participant in emergency situations. If I cannot respond or be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for and order injection, anesthesia, or surgery for this participant. I understand the information on this form will be shared on a “need to know” basis with camp staff. I give permission to photocopy this form. In addition, Camp WeHaKee has my permission to obtain a copy of my health record from my health care providers and these providers may talk with the WeHaKee’s staff about my health status.

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_