WILDERNESS TREK CHRISTIAN CAMP, INC.

Participant's name: _____ Birthdate (DOB): _____

PHYSICIAN EVALUATION

A licensed medical physician's signature is required in order to participate in WTCC's programs and activities. This form must be used. No other form can be used to replace this one.

Participation in WTCC's programs and activities involves strenuous outdoor activity that will include, but may not be limited to the following: backpacking, rappelling, five days of hiking at elevations between 8,000 and 14,500 feet. WTCC's programs and activities are conducted at altitudes above 7,000 feet involving extreme weather conditions in remote location where readily available medical care cannot be assured. I hereby affirm that upon examination of the information provided to me by the participant, there are no restrictions or limitations to participation in WTCC's programs and activities.

Signed _____ Date: _____
Licensed Physician

Printed Name: _____ Phone Number: ____ - ____ - _____

Office Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Please mail completed form to:

Wilderness Trek Christian Camp, Inc.
1003 Shell Ave.
Midland, TX 79705

OR

Scan and email completed form to:

info@wildernesstrek.org