

NATIONAL ADVENTURE CLUB (INDIA)

Room No.17(FF), Karuna Sadan, Sector-11, Chandigarh-160011



REGISTRATION FORM

Summer/Winter Adventure Camp – Manali

(/ /2026 to / /2026)

Self attested
Photo

PART-I

FULL NAME: _____

Father's/Husband's Name Shri _____

Age _____ yrs. **Sex**(M/F) _____ **Date of Birth** _____

Religion _____ **Category** (General/SC/S6T/BC/Others) _____

Marital Status (Married/Unmarried) _____ **Occupation** _____

Name of Nominee _____ **Relation with Nominee** _____

Postal Address _____

_____ **Phone** _____

Email address _____ @ _____

Sponsor's Address (if any): _____

Vegetarian/Non-Vegetarian _____

Camp life experience _____

I agree to strictly abide/adhere to the discipline and the directions of the National Adventure Club (India) during the above mentioned **Summer/Winter Adventure Camp - 2026** failing which I shall be liable for expulsion. In case of accident/injury or any loss/damage, I will not hold National Adventure Club (India), it's affiliate or its staff, wholly or partially responsible. The above entries have been made by me and are correct to the best of my knowledge and belief. **I may please be allowed to take part in the above mentioned Summer/Winter Adventure Camp – 2026.**

Place: _____

Date : _____

Applicant's signature

RISK CERTIFICATE

It is certified that I agree to detain Myself/Mr./Miss/Mrs. _____
_____ son/daughter/wife/husband of _____
for taking part in above mentioned **Summer/Winter Adventure Camp - 2026** at my own risk and no compensation will be paid to me in case of any accident/injury or any loss/damage, I will not hold the National Adventure Club (India), it's affiliate or its staff, wholly or partially responsible for any mishappening.

Place: _____

Date : _____

Signature of Applicant

Team Manager/Parent

N.B. Forms should be neatly filled in by the candidates themselves by ballpoint pen in CAPITAL letters ONLY.

PART-II

MEDICAL CERTIFICATE

Summer/Winter Adventure Camp - 2026

Photo
Attested by
Medical Officer

1. NAME	
3. HEIGHT	
5. DATE OF LAST VACCINATION (Tab, Cholera &Inoculation)	
7. CHEST EXPANSION	
9. BLOOD PRESSURE	
11. URINE EXAMINATION	
13 .BLOOD GROUP	

2. AGE	
4. WEIGHT	
6. RESPIRATION RATE AT REST	
8. PULSE RATE	
10. CONDITION OF UPPER LIMB, TOES AND FEET	
12.EYES/ EARS/ THROAT	

Applicant has not Asthma, Epilepsy or any other major deformity, Hernia and Chronic diseases.

In my opinion Mr./Ms. _____ whose signature is given below is fit to undergo above course.

SIGNATURE OF APPLICANT

SIGNATURE OF MEDICAL OFFICER WITH SEAL

REGISTRATION NO. OF THE COUNCIL	
DATED	
PLACE	
TEL/MOBILE	

Note: The medical officer should be MBBS and give his/her registration number of the council.