**Walking Mountains**

# STUDENT MEDICAL INFORMATION & RISK RELEASE

***Parent or Guardian, please print the following information. Make sure both sides are completed & signed.***

Program Name__________________________________________Program Date(s)__________________________
Student's Name________________________________________Home Phone______________________________
Date of Birth___________________________________________Cell Phone____________________________
Mailing Address_____________________________________________________________________________
Parent/Guardian's Name(s)____________________________________________work phone________________
Email____________________________________Insurance Company Name______________________________
Phone__________________________________Policy Number_______________________________________
Family Physician_______________________________________Phone___________________________________
In case of emergency, what other relative, neighbor, or friend may be called?
Name__________________________________________Relationship___________________________________
Address_______________________________________________Phone___________________________________

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Although Walking Mountains is academically oriented, some of the activities are quite strenuous if the participant is unfamiliar with such activities or is not in good physical condition. The ability to walk several miles without undue fatigue indicates reasonable physical fitness. Any previous knee or ankle problems, excessive weight, or allergies to food, medicine or insect bites are also of particular concern.

**The following information is important and will help us avoid health or medical problems before they occur.**

Age________________ Height______________ Weight____________________
Does your student have any allergies? No Yes
If yes, please list: ____________________________________________________________________________
Does your child have allergic reactions to bee stings? No Yes
Does your child have or has experienced in the past any of the following problems? If so, please specify type of problem.

Respiratory Problems: ______________________________________________________________________
Heart Condition: __________________________________________________________________________
High Blood Pressure: _______________________________________________________________________
Ankle or Knee Problems:_____________________________________________________________________
Adverse reactions to medicine: _______________________________________________________________
Other: _____________________________________________________________________________________

Date of last tetanus shot: ___________________
Is the student using any medication? No Yes
If so, what type and dosage?_________________________________________________________________
What is the medication specifically for?_______________________________________________________
Do you have any dietary restrictions? _________________________________________________________
If the student has any emotional disorders or learning disabilities that may effect his/her participation in our program, please describe this condition in order that we may better serve you. Please list any fears or phobias the student may have that require special attention. Attach an additional page if you need more room.___________________________________
_____________________________________________________________________________________________
__________________________________________________________

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Walking Mountains staff is concerned about inappropriate use of both prescription and non-prescription medication by minors. If the student is not 21 years of age he/she is not permitted to use or share *any* medication without written permission from a parent, legal guardian, or physician or under specific authorization of a Walking Mountains staff person.

I give permission for my minor son/daughter to join this educational program and I authorize Walking Mountains staff to obtain or administer medical treatment for him/her in the event of an emergency.

Signed________________________________________Date_____________________

(OVER )

## RELEASE AGREEMENT/INFORMATION OF RISK

The activities of Walking Mountains may involve strenuous physical exercise, exposure to changing weather conditions, and use of potentially dangerous equipment and tools. They also demand the total attention and responsibility of each participant, either as an individual or part of a cooperating group. In addition, these activities include the inherent risk of fatigue, mental stress, injury or death. Your permission, indicated below, acknowledges these risks, and also entrusts Walking Mountains to apply reasonable restrictions to free time pursuits that maximize safety and enhance our ability to respond to emergency.

The following is a list of *potential activities* which your son/daughter may be participating in as part of the Walking Mountains program: **backpacking, hiking, games and initiatives, outdoor cooking, conservation project, vehicle travel, night time activities, wilderness travel and survival skills, map and compass, scientific field research, and overnight camping.**

I attest that I have carefully read the information concerning potential risk. I further realize that I am voluntarily responsible for his/her participation and agree to ask for any necessary clarification concerning the Walking Mountains program and/or activities prior to signing this form.

I,________________________________*(name of parent or legal guardian),* hereby acknowledge that my son/daughter, ________________________________*(student name)* has been given my full permission to participate in the Walking Mountains program entitled_________________________________________________________.
I voluntarily elect to assume all risks of loss, damage, injury, including death, that may be sustained by my son/daughter or any property of his/hers in the course of his/her participation in this program. In consideration of the opportunity afforded him/her to participate in the above mentioned program I hereby knowingly, freely and voluntarily release, and, moreover, covenant to indemnify and hold harmless Walking Mountains, its Executive Director, Board of Directors, staff and employees from any and all liability, claims, demands or causes of action whatsoever, including claims based on negligence, arising out of any loss to me or my son/daughter in the course of or related to, participation in this program or the use of equipment supplied to my son/daughter in connection with any program. My child and I give Walking Mountains and their partners permission for reasonable and proper use of any photograph or video taken of me or my child or any written or verbal statement made by me or my child during or pertaining to this program.

**Signed**_____________________________________________________**Date**_____________________________
***(father or guardian)***
**Signed**_____________________________________________________**Date**_____________________________
***(mother or guardian)***

I have carefully reviewed the above list of activities, and I agree to participate in or undertake only those for which I have received permission. I further acknowledge the supervisory role of Walking Mountains Science Center staff in ensuring my safety despite my own perceived abilities or desire for autonomy.

**Student Signature:** ___________________________________________**Date**____________________________

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**PRE-EXISTING CONDITIONS ONLY**
If the student has a pre-existing condition that might be affected by participation in an active outdoor program at elevations exceeding 8,000 feet above sea level, please describe this condition and have a physician fill out and sign all sections below. *Fill this section out only if you believe that you may have such a pre-existing condition.*
Description of Condition: ___________________________________________________________________
Medication taken, dosage, and timing: _______________________________________________________
Other special instructions or precautions: ____________________________________________________
Physician's statement:
I_________________________________have examined_________________________________________________
*(please print)* *(student name)*
and recommend that she/he can participate in Walking Mountains programs.
Signed_________________________________________________Date_____________________________________