Registration, Health Screen and Participant Agreement

Extended Backpacking Programs

Part I: Participant Information

Participant Name ____ Date of Birth ______________________________

Age at start of program __________ Grade _________ Gender: ____

Address _____________________________________ City/State/Zip ____

If a minor: Parent/Guardian's Name ____

Parent Home Phone (_____)_________________________ Parent Work Phone (_____)__________________________

Emergency Contacts

#1. Name______________________________________ #2. Name ____

Phone # (____) _________________________________ Phone # (____) _______________________________________

Address _______________________________________ Address____

City/State/Zip __________________________________ City/State/Zip ____

Insurance Information

Please Note: Each participant is responsible for any medical expenses and should be covered by his/her own sickness and accident insurance. (The following questions must be answered for insurance records.)

Is applicant covered by a hospitalization/medical care policy? ☐ Yes ☐ No

Insurance Company Name___________________________________ Policy or Certificate # _____________________

Address ____ City/State/Zip ___________________________

Does your Insurance Company require pre-authorization? ☐ Yes ☐ No

If Yes, Phone Number: (_____)_______________

NOTE: PLEASE ATTACH A PHOTOCOPY OF THE PARTICIPANT'S INSURANCE CARD.

Mental Health History

NatureBridge requires that any student with a history of counseling that requires medication, hospitalization, or residential treatment exhibit one year of stability before they will be accepted for a program.

Has the applicant had treatment, counseling, or hospitalization with a mental health professional? ☐ Yes ☐ No

Is he/she currently receiving treatment or counseling services? ☐ Yes ☐ No

Please circle any of the applicable causes for treatment or counseling:

Suicide Attempts or Ideation

Substance Abuse

Eating Disorder

Depression

Family Issues

Other___________

Please provide specific dates and details of counseling history and medications prescribed:

____
____
____

Please provide contact information of counseling therapist: ________________________ ________________________

Name Phone

Allergies (Including Medicines, Foods, Bites, and Stings)

Please list below or circle: None

Allergy	Reaction	Medication Required

Medications

Please list below or circle: None

(List any medication you are using, including psychiatric and over the counter medication)

Medication	Condition	Dose (size & freq.)	Current Side Effects

Dietary Needs

Do you have any dietary needs? ☐ Yes ☐ No
If so, please explain (vegetarian, only eat fish, no eggs, etc.) ____ ____

Required Immunization

Immunization	Requirement	Year of Last Immunization
Tetanus	Within 10 years of program start	

Hospitalization/Emergencies

Please list any hospital or emergency department visits in the last two years, or circle: None

Dates	Reason	Length of Stay

Current Exercise Activity

Note: Please prepare physically for the course through regular exercise. You will be walking 5-10 miles per day with 30-50 lb. packs up and over mountain passes during the backpacking portion of the trip. Conditioning before your course is important for avoiding injury and staying healthy. It will add to your enjoyment and ability to participate on your course.

Current Exercise Activity	Frequency	Leisurely	Moderately	Intensely
Example: Tennis	*3 times per week*		*X*	

Additional participant comments or important information we should know:

____

____

____

____

PARTICIPANT AGREEMENT
(INCLUDING ASSUMPTION OF RISKS, RELEASE, AND INDEMNIFICATION)

REQUIRED FOR ALL PARTICIPANTS

PLEASE READ THIS ENTIRE AGREEMENT CAREFULLY. IT AFFECTS THE LEGAL RIGHTS OF PARTICIPANTS AND THEIR FAMILIES IN THE EVENT OF AN INJURY OR OTHER LOSS.

All Participants age 18 and older, including all teachers and chaperones, (referred to as "Adult Participants"), must sign this Participant Agreement. At least one parent or legal guardian (both referred to as "Parent") must sign on behalf of themselves individually as well as on behalf of their minor child or ward (referred to as "Minor Participant"). The term "I" as used in this Participant Agreement refers to the Adult Participant and/or Parent. The term "Program" refers to the NatureBridge program in which a Participant has enrolled.

In consideration of the Program, services, benefits and amenities provided by NatureBridge, a California Non-Profit Public Benefit Corporation, I hereby understand, acknowledge and agree as follows:

Activities and Risks

Activities vary from program to program, and may include hiking, stewardship activities (for example, plant removal and trail maintenance), backpacking, skiing, snowshoeing, snorkeling, kayaking, canoeing, and other water craft excursions. Some programs involve travel in NatureBridge vehicles driven by NatureBridge employees. I understand that the Program exposes Participants to a variety of risks and hazards, foreseen and unforeseen, some of which are inherent and cannot be eliminated without fundamentally altering the unique character of the Program. These inherent risks include, but are not limited to, environmental risks and hazards, including rapidly moving, deep, or cold water; plants; insect stings and bites; snakes, and predators, including large animals; falling and rolling rock; lightning; tree and tree limb fall; and unpredictable forces of nature, including weather that may change to extreme conditions without notice. Possible injuries and illnesses include allergic reactions, including, anaphylaxis; hypothermia; frostbite; high altitude illnesses; sunburn, heatstroke, and dehydration; infectious diseases such as Lyme disease, norovirus, plague or hantavirus; musculoskeletal injuries; and other possible serious conditions or injuries, including death. Emergency evacuation and medical care may be delayed twenty-four (24) hours or more due to the remote locations of some Program activities.

Assumption of the Risks

I understand that the description of the risks involved in NatureBridge activities set forth above is not complete, and that other risks may result in property loss, personal injury, or death. On behalf of myself and my Minor Participant (if applicable), I agree to assume, to the fullest extent permitted by law, all risks of participation in the Program, whether known or unknown, and whether or not such risks are described above. I understand that participation in the Program is entirely voluntary, and I consent to participation with full knowledge of the possible risks of such participation. If the Participant is a minor child, I have discussed the Program activities and risks with them, and confirm that the child wishes to participate in the Program.

Release and Indemnification

I, an Adult Participant or Parent of a Minor Participant, for myself and on behalf of such Minor Participant, agree to release, indemnify, protect, and hold harmless, and promise not to sue, NatureBridge and/or any of its officers, directors, employees, agents, contractors, and insurers (the "Released Parties"), to the maximum extent permitted by law, with respect to any and all claims, demands, damages, attorneys' fees, litigation costs, losses, or liabilities, including, but not limited to, claims for property loss, personal injury and/or wrongful death, which I or my Minor Participant may suffer, arising out of or in any way related to my, or my Minor Participant's, participation in the Program. The claims hereby released and indemnified against include those caused by or arising from the negligence of a Released Party, or any of them.

Medical Authorization

I represent that the medical information I have provided above is current, accurate and complete.

I authorize NatureBridge staff to administer first aid, including, where permitted by applicable law, the administration of epinephrine by auto-injector, as well as the administration of "over the counter" medications, including aspirin, Tylenol, ibuprofen, Benadryl, Neosporin, Imodium, laxatives and similar medications. If my Minor Participant has a known life-threatening allergy, or if I have been advised by a health-care provider that the Minor Participant should be prepared for a possible serious allergic reaction, my Minor Participant has been provided with auto-injectable epinephrine and has been instructed by a physician as to its use; in addition, I have instructed my Minor Participant to have the auto-injectable epinephrine on their person and available at all times during the Program. If my Minor Participant is enrolling in the Program as part of a school or other group, I have also informed the person in charge of the school or other group of this allergy and any applicable physician -prescribed protective measures. I confirm that I have, or my Minor Participant has, the ability to hike up to 5 miles per day with up to a 2,000 feet elevation gain without presenting a risk of harm to myself, my Minor Participant, and/or others. I authorize any adult chaperone or member of NatureBridge staff to obtain medical care for my Minor Participant (or for me, if I am unable to consent), and hereby consent to any X-ray, examination, anesthetic, diagnosis, treatment and/or hospital care that may be recommended by a licensed physician and/or dentist. In the event of minor illnesses or injuries, I understand that NatureBridge will attempt to contact me at the earliest practicable opportunity. In the event of a major illness or injury, I understand that NatureBridge will attempt to contact me before the commencement of any medical treatment, unless my Minor Participant's condition is such that treatment must be commenced immediately before contact with me can be made. If I cannot be reached, this authorization remains in full force and effect.

I agree to assume full financial responsibility for the costs of any early departure, back-country evacuation, and/or medical care or treatment that I or my Minor Participant may receive (including transportation to and from the Program). I understand that NatureBridge reserves the right to refuse participation to any person who NatureBridge determines, in its sole discretion, may present a risk of harm to themselves or others.

Other Provisions

I agree that NatureBridge and/or its designees may use, without restriction or compensation, my likeness, and/or that of my Minor Participant, whether in photographs or video, as well as any writing, artwork and/or testimonials created by me or my Minor Participant and submitted to NatureBridge. I agree that once submitted, these materials shall become the property of NatureBridge and may be used for marketing purposes.

I understand that during part of the Program, my Minor Participant will be under the supervision of teachers, chaperones, and other adults who are not NatureBridge employees, and who have not been selected, and are not supervised, by NatureBridge. I understand and agree that NatureBridge is not responsible for the actions of any such individuals.

NatureBridge uses independent contractors for some services, and such independent contractors, and not NatureBridge, are solely responsible for any losses or injuries caused by their acts or omissions.

I understand that this Participant Agreement is intended by NatureBridge to have as broad an effect as the law permits, and that if any part of this Participant Agreement is found to be invalid for any reason, the remainder of the Participant Agreement shall remain valid and fully enforceable.

I agree that if there is a dispute between me or my Minor Participant, on the one hand, and a Released Party, on the other, such dispute will be governed by the substantive laws of the State of California, and that any lawsuit against any of the Released Parties will be filed and maintained in a court of competent jurisdiction in San Francisco County, California.

I have been advised to consult with an attorney of my choosing if I have any questions concerning the provisions and/or translation of this Participant Agreement. I certify that I have carefully read this Participant Agreement, I understand its terms, and am signing it voluntarily. I have had any questions concerning the Program answered to my satisfaction.

I understand that in the event of any dispute or issue regarding any translation of this Participant Agreement, the English version of this Participant Agreement shall control.

Name of Participant ____

Print Name

____ ______________________________ _____/_____/_____

Parent or Legal Guardian Signature **Print Name** **Date**

(For Minor Participant)

____ _____/_____/_____

Adult Participant Signature (if age 18 or older) **Date**

14836-3440-4873 4848-7268-1993, v. 3

Part II: Medical Exam (to be filled out by a Physician, LNP, or PA)

*** This form ***must*** be used – **alternate forms will not be accepted.** ***

This page is to be completed and signed by a Physician, Licensed Nurse Practitioner, or Physician's Assistant.

To the examining physician:

Our summer backpacking program is strenuous in nature. We hike approximately 5-10 miles daily at high altitudes with 30-50 pound packs. Our participants can be far removed from hospital-based medical support services and as much as 48 hours from definitive care.

Your careful examination is an important part of our medical screening process. By signing this form you indicate that the participant is in good physical condition, adequate for successfully participating in our strenuous summer backpacking trips.

Please fill out completely.

Exam Date____________________ ***NOTE: Exam must take place within one year of program start date.***

Patient's Name ____

Height ____ft. ____in. Weight _____lbs. Blood Pressure _________/__________ Pulse____________

Circle if normal, describe only if abnormal:

Eyes ____

Ears ____

Nose ____

Throat & Mouth _________________________________

Thyroid ______________________________________

Lymph nodes ___________________________________

Neck ____

Back ____

Extremities ____________________________________

Shoulders _____________________________________

Knees _______________________________________

Ankles _______________________________________

Feet ____

Skin ____

Heart _______________________________________

Other _______________________________________

Summary of Active Medical Problems and Restrictions

Please list below or circle: None

____

____

____

____

____

Conditions and Symptoms

Does the patient have or have they had any of the following conditions or symptoms?

Condition		Condition		Condition	
1. Tuberculosis	☐ Yes ☐ No	11. Kidney Infection	☐ Yes ☐ No	21. Ankle problem	☐ Yes ☐ No
2. Chronic Cough	☐ Yes ☐ No	12. Thyroid Problems	☐ Yes ☐ No	22. Knee problem	☐ Yes ☐ No
3. Asthma	☐ Yes ☐ No	13. Hearing Impairment	☐ Yes ☐ No	23. Broken bones	☐ Yes ☐ No
4. Diabetes	☐ Yes ☐ No	14. Vision Impairment	☐ Yes ☐ No	24. Motion sickness	☐ Yes ☐ No
5. Hypoglycemia	☐ Yes ☐ No	15. Circulation Problems	☐ Yes ☐ No	25. Learning disability	☐ Yes ☐ No
6. Recent exposure to active TB	☐ Yes ☐ No	16. Respiration Issues	☐ Yes ☐ No	26. Medical Equipment/ Devices	☐ Yes ☐ No
7. Positive TB Test	☐ Yes ☐ No	17. Headaches	☐ Yes ☐ No	27. Special diet	☐ Yes ☐ No
8. Active Hepatitis	☐ Yes ☐ No	18. Intestinal Problems	☐ Yes ☐ No	28. Sleepwalking	☐ Yes ☐ No
9. Seizure Disorder	☐ Yes ☐ No	19. Bladder Infection	☐ Yes ☐ No	29. Eating disorder	☐ Yes ☐ No
10. Bleeding Disorder	☐ Yes ☐ No	20. Skin Problem	☐ Yes ☐ No	30. Other:	

If you have answered “yes” to any of the above items, please explain below. Include the following:

- What specific symptoms are occurring
- How long symptom/condition lasts
- Date of last occurrence
- How often symptom/condition occurs
- How you care for symptom/condition
- How symptom/condition restricts applicant’s activity in any way (including applicant’s ability to hike)

NOTE: If Patient has **severe** asthma or **severe** allergies, please provide an asthma or anaphylaxis emergency action plan.

Item No.	Detailed Description (including restrictions, if any)

Physician's Signature Required

How long have you known the applicant? ______________________________

Name of examining Physician (please print): ______________________________

Address: ____ ______________________________Telephone: ________________

Physician’s Signature ______________________________ Date ____________________