



SESI 2010 Student Registration

July 26-28, 2010

Registration Deadline – July 7, 2010

Please complete the following registration form for each individual, including the IslandWood Release Form, and mail them to the address below.

_____ Male Female
First Name Last Name Age (July 2010)

How would you like your first name to read on your name badge?

Address

City/State/Zip

Phone

Email address

How did you hear about the conference?

School

School District (if applicable)

What grade will be in Sept. 2010: _____

I would like to share a room with:

Dietary Restrictions:

Special Accommodations:

Mail completed, signed, forms to:

IslandWood – Attn: Cathy Sanford
4450 Blakely Avenue, NE
Bainbridge Island, WA 98110
Fax 206.855.4301

IslandWood Release Form (Youth-under 18 years old)

PARENT OR GUARDIAN : PLEASE COMPLETE BOTH SIDES OF THIS FORM IN INK.

YOUTH'S NAME:							
Event:	SESI 2010			Date:	July 26-28, 2010		
Participant's Age:		Birth Date:		Gender:	M	F	
Address:							
Parent/Guardian:				Email:			
Evening Phone:		Cell Phone:		Day Phone:			
EMERGENCY CONTACT NAME:							
Phone:				Email:			

ACKNOWLEDGEMENT AND RELEASE AUTHORIZATION FOR MEDICAL TREATMENT:

I am familiar with the program for which the participant is registering. I understand that this program may involve activities of a physical nature that will take place in an outdoor environment, and may include hiking on trails and rough terrain and in the vicinity of bodies of water and walking on high bridges and canopy walkways. I further understand that there are risks associated with these kinds of activities.

As a condition of participation in this program and/or the use of IslandWood equipment and/or facilities, I agree that I will be fully responsible for any and all personal injuries, property damage, loss of personal property, or any other loss that may result from my child's participation, and I agree not to hold IslandWood responsible, and their respective agents and employees, to the fullest extent permitted by law, for any damages, liabilities or expenses that result from participation in this program and/or the use by the participant of any IslandWood facilities and /or equipment.

If my child is taking any medication, I understand that IslandWood will not be responsible for administering such medication, and that I will be required to make any necessary arrangements for the administering of such medication. I understand that IslandWood's staff has a standing physician's directive that allows the administration of benadryl and epinephrine for severe allergic reactions (anaphylaxis). I hereby give permission to personnel of ISLANDWOOD to authorize any x-rays, tests, procedures, anesthetic, surgery or treatment on behalf of, and to provide or arrange for any transportation of, my child as may be required in the event of an emergency. If I, or the emergency contacts designated previously, cannot be contacted, I hereby give permission to a licensed physician, or other qualified health care provider as may be appropriate, to administer such treatment to my child, the participant, as may be necessary under the circumstances, including the hospitalization of my child.

I certify that I have completed the Health History and Health Questionnaire on the back of this form fully and accurately and accept full responsibility for any errors or omissions.

I certify that my child and I have read the Behavioral Expectations at IslandWood and agree to its terms.

PHOTOGRAPH AUTHORIZATION: I agree that any photographs/video taken by any IslandWood personnel of my child as a program participant shall be the property of IslandWood, and may be used by IslandWood, at its discretion, for any publicity, education, marketing and/or advertising purposes and I hereby consent to and authorize such use without restriction.

I HAVE READ THE AGREEMENT, FULLY UNDERSTAND IT, AND GRANT PERMISSION FOR MY CHILD TO PARTICIPATE IN THE PROGRAM IDENTIFIED ABOVE.

Signature of Parent or Legal Guardian:		Date:	
Print Name & Relationship to Child:			

BEFORE RETURNING THIS FORM WITH THE REGISTRATION INFORMATION,
BE SURE TO COMPLETE THE MEDICAL/DIETARY QUESTIONS ON NEXT PAGE!!!

<p>Physical Condition:</p> <p>Please list any non-allergy physical/medical conditions that would be helpful for us to know about this child in an emergency. There is space in the next box for allergies.</p> <table border="1" style="width: 100%; height: 40px; border-collapse: collapse;"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table> <p>Is this child capable of walking 3 miles, with frequent rest stops, in the course of a day?</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">Yes</td> <td style="width: 50%; text-align: center;">No</td> </tr> </table>					Yes	No	<p>Medications:</p> <p>Is the child taking any medications?</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">Yes</td> <td style="width: 50%; text-align: center;">No</td> </tr> </table> <p>If yes, please list and describe:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;"></th> <th style="width: 45%;">Name of Medication</th> <th style="width: 45%;">Dosage & Instructions</th> </tr> </thead> <tbody> <tr><td>1.</td><td> </td><td> </td></tr> <tr><td>2.</td><td> </td><td> </td></tr> <tr><td>3.</td><td> </td><td> </td></tr> <tr><td>4.</td><td> </td><td> </td></tr> </tbody> </table> <p>Is the child current on tetanus injections?</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">Yes</td> <td style="width: 50%; text-align: center;">No</td> </tr> </table>	Yes	No		Name of Medication	Dosage & Instructions	1.			2.			3.			4.			Yes	No			
Yes	No																												
Yes	No																												
	Name of Medication	Dosage & Instructions																											
1.																													
2.																													
3.																													
4.																													
Yes	No																												
<p>Allergies</p> <p>List any foods that the child is allergic to and cannot eat. IF THE CHILD HAS ANY FOOD ALLERGIES, A <i>FOOD ALLERGY ACTION PLAN</i> MUST BE COMPLETED BY A PHYSICIAN & ATTACHED TO THIS FORM.</p> <table border="1" style="width: 100%; height: 40px; border-collapse: collapse;"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table> <p>Please indicate any non-food allergies that the child has.</p> <table border="1" style="width: 100%; height: 40px; border-collapse: collapse;"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>									<p>Dietary Preferences</p> <p>(This is for food preferences & sensitivities only. IF YOUR CHILD HAS FOOD ALLERGIES, COMPLETE THE BOX ON THE LEFT.)</p> <p>Please mark any that apply:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 20%;">Vegetarian</td><td> </td></tr> <tr><td>Vegan</td><td> </td></tr> <tr><td>No pork</td><td> </td></tr> <tr><td>No red meat</td><td> </td></tr> <tr><td>No nuts</td><td> </td></tr> <tr><td>No dairy</td><td> </td></tr> <tr><td>No wheat</td><td> </td></tr> <tr><td>Other:</td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>	Vegetarian		Vegan		No pork		No red meat		No nuts		No dairy		No wheat		Other:					
Vegetarian																													
Vegan																													
No pork																													
No red meat																													
No nuts																													
No dairy																													
No wheat																													
Other:																													
<p>Miscellaneous</p> <p>Is there anything else that you believe it is important we know in regards to this child's participation in this program? If so, please describe:</p> <table border="1" style="width: 100%; height: 40px; border-collapse: collapse;"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>					<p>Health Care</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 60%;">Physician's Name:</td><td> </td></tr> <tr><td>Physician's Phone:</td><td> </td></tr> </table> <p>Is child covered by any medical insurance:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">Yes</td> <td style="width: 50%; text-align: center;">No</td> </tr> </table> <p>If so:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 20%;">Carrier</td><td> </td></tr> <tr><td>Group #</td><td> </td></tr> <tr><td>I.D #</td><td> </td></tr> <tr><td>Subscriber Name</td><td> </td></tr> </table>	Physician's Name:		Physician's Phone:		Yes	No	Carrier		Group #		I.D #		Subscriber Name											
Physician's Name:																													
Physician's Phone:																													
Yes	No																												
Carrier																													
Group #																													
I.D #																													
Subscriber Name																													

****Please read and sign the front of this page.****