IslandWood Release Form (Adult-18 years and older)

PLEASE COMPLETE BOTH SIDES OF THIS FORM IN INK

Participant's Name: _____

School/Group:_____ Program Dates:_____

Participant's Age: _____ Birth Date:_____ Gender: : ☐Female ☐Male ☐Other

Address (include city and zip): _____

Work Phone: _____ Home Phone: _____ Cell Phone: _____ Email: _____

EMERGENCY CONTACTS:

1) Name: _____ Day Phone: (____)

_____

Evening Phone: (___) _____ Pager/Cell: (___) _____ E-mail: _____

2) Name: _____ Day Phone: (____) _____

Evening Phone: (___) _____ Pager/Cell: (___) _____ E-mail: _____

Please read the following carefully before signing:

ACKNOWLEDGEMENT AND RELEASE AUTHORIZATION FOR MEDICAL TREATMENT:

I am familiar with the program for which I, the participant, am registering. I understand that this program involves 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, overnight camping 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 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 me, the participant, of any IslandWood facilities and /or equipment.

If I am taking any medication, I understand that IslandWood will not be responsible for administering such medication. 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, me, the participant, as may be required in the event of an emergency. If 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 me, the participant, as may be necessary under the circumstances, including hospitalization.**I certify that I have completed the Health History and Health Questionnaire on the reverse side of this form fully and accurately and accept full responsibility for any errors or omissions.**

MEDIA AUTHORIZATION: I agree that any photographs or videotape taken by any IslandWood personnel of myself 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, AND FULLY UNDERSTAND IT, AND AGREE TO BE BOUND BY ITS TERMS.

Signature: _____ Date: _____

BE SURE TO COMPLETE THE MEDICAL/DIETARY QUESTIONS ON REVERSE!!!

Physical Condition

Please list any physical/medical conditions that would be helpful for us to know in an emergency:
_____
_____
_____
_____

Are you capable of participating in an easy to moderate 3-mile hike, with frequent rest stops? ____yes ____no

Medications

Are you taking any medications? _____yes _____ no

If so, please list and describe:

Name of Medication Dosage & Instructions
1)_____
2)_____
3)_____
4)_____

Food Restrictions

Please indicate any dietary restrictions due to preference, religious practice, lactose intolerance, food sensitivity, etc. The following are NOT due to a food allergy:

Please circle any that apply:

No meat (vegetarian)
No animal products (vegan)
No pork
No red meat
No nuts
No dairy
No wheat/gluten
Other restrictions: _____
_____
_____

Allergies

Have you been diagnosed for any **food allergies**? If yes, please describe:
_____
_____
_____

Do you carry an epinephrine auto-injector for these food allergies**?**
Yes __ No __

Please name any **non-food allergies** that you have. (If allergies are severe, medication must be carried):

_____
_____
_____

Miscellaneous

Is there anything else that you believe is important for us to know in regard to your participation in this program? If so, please describe:
_____
_____
_____
_____
_____
_____

Health Care

Name of physician: _____
Physician's Telephone: _____

Is participant covered by any medical insurance? __yes __no
If so:
Carrier: _____
Group # _____
I.D. # _____
Subscriber Name (if different than participant):
_____