

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 Identity: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Email: _____

EMERGENCY CONTACT:

Name: _____ Day Phone: (____) _____

Evening Phone: (____) _____ Cell: (____) _____ E-mail: _____

Please read the following carefully before signing:

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 stays, and walking on high bridges and canopy walkways. I further understand that there are risks associated with these kinds of activities.

Covid-19 Warning: An inherent risk of exposure to Covid-19 exists in any area, public or private, where people are present together. Covid-19 is an extremely contagious disease that has been known to lead to severe illness and to death. In addition, there is evidence of asymptomatic cases of Covid-19 whereby individuals may transmit this disease unknowingly to other individuals. By visiting IslandWood, I voluntarily assume all risks related to exposure to Covid-19.

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: _____

Print Name: _____

**BEFORE RETURNING THIS FORM TO YOUR SCHOOL,
BE SURE TO COMPLETE THE MEDICAL/DIETARY QUESTIONS ON REVERSE!!!**

<p>Physical Condition</p> <p>Please list any physical/medical conditions that would be helpful for us to know in an emergency:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Are you capable of participating in an easy to moderate 3-mile hike, with frequent rest stops? ____yes____no</p>	<p>Medications</p> <p>Are you taking any medications? ____yes____no</p> <p>If so, please list and describe:</p> <table border="0"> <thead> <tr> <th style="text-align: left;">Name of Medication</th> <th style="text-align: left;">Dosage & Instructions</th> </tr> </thead> <tbody> <tr> <td>1) _____</td> <td>_____</td> </tr> <tr> <td>2) _____</td> <td>_____</td> </tr> <tr> <td>3) _____</td> <td>_____</td> </tr> <tr> <td>4) _____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	Name of Medication	Dosage & Instructions	1) _____	_____	2) _____	_____	3) _____	_____	4) _____	_____	_____	_____
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4) _____	_____												
_____	_____												
<p>Food Restrictions</p> <p>Please indicate any dietary restrictions due to preference, religious practice, lactose intolerance, food sensitivity, etc. The following are NOT due to a food allergy:</p> <p>Please circle any that apply:</p> <p>No meat (vegetarian)</p> <p>No animal products (vegan)</p> <p>No pork</p> <p>No red meat</p> <p>No nuts</p> <p>No dairy</p> <p>No wheat/gluten</p> <p>Other restrictions: _____</p> <p>_____</p> <p>_____</p>	<p>Allergies</p> <p>Have you been diagnosed for any food allergies? If yes, please describe:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Do you carry an epinephrine auto-injector for these food allergies? Yes No __</p> <p>Please name any non-food allergies that you have. (If allergies are severe, medication must be carried):</p> <p>_____</p> <p>_____</p> <p>_____</p>												
<p>Miscellaneous</p> <p>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:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Health Care</p> <p>Name of physician: _____</p> <p>Physician's Telephone: _____</p> <p>Is participant covered by any medical insurance? __yes no</p> <p>If so:</p> <p>Carrier: _____</p> <p>Group # _____</p> <p>I.D. # _____</p> <p>Subscriber Name (if different than participant): _____</p> <p>_____</p>												

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