Youth Leadership Adventures: *Participant Information and Release*

To be filled out by a Responsible Adult (Parent or Guardian if participant under 18) or Adult Participant (18 & over). By providing this confidential medical information, you are consenting to NCI providing it to staff and emergency medical providers or first responders who may have a reasonable need to know the information in order to provide your child with an accommodation and/or emergency medical assistance.

PARTICIPANT INFORMATION

Date: _____

Last Name:		Date of Birth:	
First & Middle Name:		Language(s) spoken:	
Home Address, City, State, & Zip Code:		Are you covered by health insurance?	**Yes** ☐ **No** ☐ If yes, with whom: Policy #: Phone number:
Phone Number(s):			
Email Address:			
Current gender identity:		Family physician:	Name: Phone number:
Sex assigned at birth:			

Emergency Contact #1:		**Emergency Contact #2:**	
Name:		Name:	
Relationship:		Relationship:	
Phone Number(s):		Phone Number(s):	
Email Address:		Email Address:	
Languages spoken :		Languages spoken :	

ACTIVITY LEVEL:

We make all reasonable efforts to accommodate participants, however, it is your responsibility to confirm your child is medically fit for participation and ask that you consult with your family physician if you have any concerns regarding your child's ability to participate in program activities.

In what athletic activities do they regularly participate? Please list activity and duration:

NCI programs may consist of some or all of the following activities in some or all of the following conditions:

- Daylong hikes carrying up to a 50 lb. pack.
- Paddling a canoe for many days in a row.
- Hiking up and down steep terrain carrying heavy tools or supplies.
- Performing service projects involving shoveling, swinging tools, bending, squatting, and walking on uneven ground.
- Participants will sleep, hike, and work in the outdoors, possibly in cold, hot, humid, rainy or higher altitude conditions.

Is the participant able to participate in all these activities? **Yes** ☐ **No** ☐ If no, please explain:

GENERAL HEALTH QUESTIONS:

Height: _____ **Weight:** _____ **Check** to indicate whether the participant has had any of the following conditions in the **past 2 years:**

- ☐ Chronic illness/condition
- ☐ Hospitalized for any reason
- ☐ Broken bones
- ☐ Problems with joints (e.g. sprains)
- ☐ Bad headaches/migraines
- ☐ Head injury
- ☐ Back pain/problems
- ☐ Frequent ear infections
- ☐ Chest pains
- ☐ Seizures or epilepsy
- ☐ Dizziness or fainting
- ☐ Heart condition
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Hepatitis
- ☐ Infectious condition
- ☐ Urinary Tract Infections
- ☐ Digestive conditions (i.e. constipation, acid reflux, ulcers, Crohn's disease, Irritable Bowel Syndrome)
- ☐ Menstrual abnormalities
- ☐ Hives
- ☐ Tobacco products use

Please explain any checked boxes. (Attach additional pages if necessary)

Please use this space to provide any additional information about the participant's physical, emotional, or mental health of which NCI should be aware (attach additional pages if necessary):

ALLERGIES:

Please list all allergies to Medications, Food or Environment (insect stings, hay fever, asthma, etc.) Attach additional pages if necessary:

Allergy	Date of Last Reaction	Qualify Severity (Low, Moderate or Severe)	Description of Reaction	Treatment	Do you have a prescription for Epinephrine? *

If you have a prescription for Epinephrine, you must bring two Epi-Pens on your trip.

Has the participant ever been stung by a bee? **Yes** ☐ **No** ☐ If yes, did they have any kind of reaction? (ie: hives) **Yes** ☐ **No** ☐

If yes, please describe the reaction:

FOOD:

Does the participant have any special dietary restrictions? (Vegetarian, gluten-free, lactose-free, or sensitive etc.) **Yes** ☐ **No** ☐

If yes, please describe:

ASTHMA:

Does the participant have Asthma? **Yes** ☐ **No** ☐ If yes, please complete the following section (add additional sheets, if necessary):

When were you diagnosed with asthma?	
What causes or triggers your asthma episodes?	
What are your symptoms when having an asthma episode?	
When was your last asthma episode?	
How often do you have asthma episodes?	
*What, if any, medications do you require?	
When did your medication or dosage last change?	
Which description best describes your asthma's current condition?	☐ Stable ☐ Worsening ☐ Improving

Have you ever required emergency treatment or hospitalization for your asthma? **Yes** ☐ **No** ☐ If yes, when and what were the circumstance?

If you have a prescription for treating your asthma, you must bring it on your trip. If your prescription is for an inhaler, you must bring two inhalers on your trip.

If the participant is taking any medications to manage or treat Allergies, ADD or Asthma, complete a medications questionnaire (p.4) for each medication taken. Please make additional copies of the form as needed and attach to this application.

LEARNING/MENTAL/EMOTIONAL HEALTH HISTORY:

Has the participant experienced any of the following in the past 2 years? Diagnosed or Undiagnosed?

- ☐ ADHD
- ☐ Anxiety Disorder
- ☐ Depressive Disorder
- ☐ Bipolar Disorder
- ☐ Disruptive and Conduct Disorder
- ☐ Intellectual Disorder
- ☐ Obsessive Compulsive Disorder
- ☐ Eating Disorder
- ☐ Learning Disability
- ☐ Personality Disorder
- ☐ Schizophrenia Spectrum Disorder
- ☐ Trauma and Stressor Related Disorder
- ☐ Suicide ideation
- ☐ Suicide attempt
- ☐ Substance Related Disorder
- ☐ Autism Spectrum Disorder
- ☐ Other: _____
- ☐ None of the above (skip to next section)

If yes to any of the above, please provide more information:

What behavior led to diagnosis, and how does it affect the participant's daily life?

Has the participant received treatment or therapy for any of the above? **Yes** ☐ **No** ☐ If yes, please describe:

Has the participant taken medication for any of the above?

MEDICATIONS BEING TAKEN:

Please list ALL medications the participant is taking routinely. Please include all over-the-counter or nonprescription drugs. For prescribed medications, make sure the prescription will remain current for the duration of the program.

Does the participant take medications on a routine basis? Yes ☐ No ☐ If yes, please describe below:

Medication:	Reason for Taking:

Further information is required on all medications that are taken routinely. For each medication listed above, complete a medications questionnaire below. **Please make additional copies of this page as needed and attach to this form**.

Is there any medication the participant takes on a routine basis that they are planning on discontinuing (not taking) during the NCI program? **Yes** ☐ **No** ☐ Please list, if any:
Is there any additional information that may be helpful to us? (Attach additional pages if necessary):

MEDICATIONS QUESTIONNAIRE:

Dear Parent, Guardian, or Adult Participant,

As a way to better serve your needs or those of your child, we ask, in consultation with your family physician, that you complete the following questionnaire regarding their medications and return it to us. This questionnaire will be kept on file, confidentially, with the member's other medical information and will be provided to NCI staff with a reasonable need to know in order to provide assistance or emergency medical response in the field.

If the participant is taking more than one medication, please make additional copies and complete a separate questionnaire for each medication.

- If participant has a prescription for **Epinephrine** they must bring two Epi-pens on their trip.
- If participant has a prescription for an **asthma inhaler**, they must bring two inhalers on their trip.

Participant's name:		Dosage:	
Medication name:		What time do you take it:	
Used to Treat:		How long have you been taking this medication?	

Common side effects (i.e. dry mouth, insomnia, loss of appetite, sun sensitivity):
Harmful interactions (i.e. do not give advil/ibuprofen while taking this medication):
This medication should be taken: ☐with food ☐with water ☐on an empty stomach ☐other (describe):
Describe medication's physical appearance (i.e. white tablet, 1/4 inch in diameter):
Describe any circumstances or side effects related to this medication for which NCI staff should immediately call your family physician or emergency medical personnel:
If your child misses taking a dose at the usual time they should: ☐ Take the medication at the next scheduled time ☐ Take the medication immediately ☐ Take a double dose at the next scheduled time ☐ Immediately call our family physician ☐ Immediately call emergency medical personnel (911) ☐ Other (describe):

AUTHORIZATIONS

The information provided in this document is correct and complete to the best of my knowledge. The person herein described has permission to engage in all program activities except as noted. I hereby give permission to NCI to provide routine health care, dispense prescribed medications, administer epinephrine in the event of anaphylaxis, and seek emergency medical treatment including ordering x-rays or critical tests. In the event I cannot be reached after a reasonable effort in an emergency, I hereby give permission to the licensed medical provider or emergency first responder selected by NCI to secure and administer treatment, including hospitalization, for the person named above. I give permission to NCI to arrange necessary transportation for me/ the person named above. I accept full responsibility for the costs of medical treatment and/or transportation provided to the person named above. I also give my permission to NCI staff to provide over the counter medication in the event of minor illness in the event I cannot be reached after reasonable effort (ie: Tylenol, Motrin, antacids, etc.). I agree to the release of any records necessary for insurance purposes.

I consent to NCI providing confidential medical information to NCI staff and emergency medical providers with a reasonable need to know the information in order to provide the above named person with an accommodation and/or emergency medical assistance. This completed form may be photocopied for use out of the office by NCI staff.

I understand that the participant's acceptance into this program is contingent on the accurate completion of these forms and approval of our medical screening team. You may be contacted if follow-up is needed.

Participant Signature:	Print Name:	Participant Age:		Date:
x_____			☐ check if 18 years or over as of start date of activity	

Legal guardian on behalf of minor participant (if under 18):	Print Name:	Date:
x_____		

Please read and sign the release form on the last page as well →

ASSUMPTION OF RISK AND AGREEMENTS OF RELEASE AND INDEMNITY

I understand that I (or my child) will be participating in activities provided by North Cascades Institute, a Washington nonprofit corporation, and its directors, employees, volunteers, agents, associates and independent contractors ("NCI"). The activity in which I (or my child) will be participating has been described to me and NCI staff have been available to answer my questions.

I acknowledge NCI's activities involve known and inherent risks, as well as unknown/unanticipated risks. Inherent risks may include those ordinarily associated with moderate to vigorous physical activity in high-altitude or wilderness terrain. Activities can occur in remote places where communication may be difficult and medical care significantly delayed. Travel may be by canoe, kayak, motorboat, automobile, van, bus or on foot, over rugged unpredictable off-trail terrain including boulder fields, downed timber, rivers, rapids, river crossings, mountain passes, snow and ice, steep slopes, slippery rocks, steep crevassed glaciers, ocean tides and currents, waves and reefs. Activities may include hiking, backpacking, mountaineering, canoeing, kayaking, cooking with stoves and working with sharp tools. I understand that travel and outdoor activities will be subject to unpredictable forces of nature (may cause a delay in departure) including extreme weather, falling rock, avalanches, lightning, wildfires and earthquakes, insects, snakes, and wild animals, including predators whose behavior cannot be predicted, all of which may cause serious harm. Participants may be exposed to infectious disease, contagious viruses, polluted or contaminated water; equipment may fail or malfunction despite reasonable maintenance and use; errors of judgment or negligence may occur, by instructors, co-participants or myself. The preceding risks, hazards and dangers may result in a variety of illnesses and injuries including, but not limited to, hypothermia, frostbite, high-altitude illnesses, heat stroke, heat exhaustion, dehydration and suffering sprains, fractures, traumatic brain injuries, cold water immersion, drowning and other trauma including sickness, infection, mental distress, disability, illness, or even death.

I expressly agree and promise to accept and assume all of the risks existing in the NCI activity for which I am (or my child is) participating, including, but not limited to, those listed above. Participation in this activity is purely voluntary, and participation is elected in spite of the risks. I also hereby voluntarily waive any right to recovery, release, forever discharge and agree to indemnify and hold harmless NCI, its directors, trustees, staff, employees, volunteers, agents, associates and independent contractors ("Released Parties") from any and all claims, including claims for bodily injury, illness, and death, demands or causes of action that are in any way connected with my (or my child's) participation in this activity or the use of NCI's equipment or facilities, including all such claims that allege negligent acts or omissions of NCI to the fullest extent permitted by law. **I hereby agree to indemnify NCI and all Released Parties from any claim made by me or my heirs or survivors on account of any injury or loss that I (or my child) may suffer arising in any way out of the activity. I further indemnify NCI and all Released Parties from any claim that might be brought by a co-participant arising in any way from my (or my child's) conduct or as a result of my (or my child's) participation.**

The following provisions apply to all NCI activities, wherever they occur:

- **I am (or my child is) in general good health and without any medical or physical condition that could interfere with participation in the NCI activity or interfere with my (or my child's) health or safety or the safety of any other participant.** I certify that I have insurance to cover any injury or damage I (or my child) may cause or suffer while participating, or else I agree to bear the costs of such injury or damage, including the cost of any evacuation and medical care. I consent to NCI providing confidential health care information to staff and/or emergency medical personnel with a reasonable need to know such information for purposes of accommodating or rendering aid to me (or my child).
- I authorize and consent to NCI, National Park Service (NPS), Forest Service (FS), or their agents, taking photographs, video, and audio of my (or my child's) participation in its programs, and to the unrestricted use and publication of my (or my child's) name and such photos, videos, or audio to promote the activities of NCI, NPS or FS. The same usage permission applies to any photos, video, or audio provided to NCI by myself or my child.
- I agree that in the event I should have any claim against NCI or any Released Party such claim or suit shall be brought in the Superior Court of State of Washington, for Skagit County, and that substantive Washington law (and not only conflict of law rules) rather than the law of any other state or jurisdiction shall be applied in any legal action involving the interpretation, validity and/or enforceability of this agreement, and that any legal action resulting from my participation in this activity shall be brought only in the aforesaid Superior Court.
- I agree that in the event any portion of this agreement is deemed invalid or unenforceable, all other portions of this agreement shall remain in full force and effect.

By signing this document, I acknowledge that I have had sufficient opportunity to read this entire document and have it independently reviewed. I acknowledge that this document is a contract and not a mere recital and shall remain in effect for all programs sponsored by NCI in which I participate. I have read and understood it, and I agree to be bound by its terms. Any form of signature shall be treated as an original, including all electronic or digital, faxed or scanned images, or other forms of signatures authorized by law.

Participant Signature:	Print Name:	Participant Age:	Date:
X_____		☐ check if 18 years or over as of start date of activity	

Legal guardian on behalf of minor participant (if under 18):	Print Name:	Date:
X_____		

North Cascades Institute admits students and participants of any race, color, national and ethnic origin, religion, sex, sexual orientation, gender identity, military or marital status, age, sensory, physical or mental disability or any other legally-protected status to all the rights, privileges, programs, and activities generally accorded or made available to students and participants at the Institute. The Institute does not discriminate on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity, military or marital status, age, sensory, physical or mental disability, genetic information or any other basis prohibited by law in administration of its educational policies, admissions policies, scholarship and loan programs, and other administered programs.