



Wilderness Trail, Inc.
www.wtrail.com

**INFORMED CONSENT
HEALTH INFORMATION AND PERMISSION
TO TREAT FORM**

Revised for 2012

Please write in blue ink and bear down hard when writing. A copy of this form is carried by the hiker in their backpack, one copy by the group leader, and one copy retained by Wilderness Trail at the base camp (this copy signed by attending staff person upon arrival at registration table).
All spaces must be filled in.

You and/or your child are about to participate in a wilderness backcountry adventure. Although many precautions are taken to insure safety, inherent in any outdoor experience are certain potential dangers. These include falls, animal incidents, lost hiker, bee and hornet stings, hypo/hyperthermia, illness related to unsafe water, and many others. Immediate medical help is not always available for emergencies. If needed, medical help will be summoned as quickly as possible and any needed medical expenses are assumed by hiker and/or parent/guardian. You and/or your child are part of a group but are not under continual visual supervision by staff. Staff and Servant Leaders (age 18 or older) may administer medical care and over-the-counter medicines as needed. Should search and rescue be needed, expenses are assumed by hiker and/or parent/guardian.

Full Name _____
Parent / Guardian _____
Street Address _____
Mailing Address (if different) _____
City / State / Zip _____
WT Summer Events Completed _____ #WT Weekend Events Completed _____

Event # _____ Event Dates _____
Group / Church _____
Participant Email Address _____
Parents(s)/Family Email Address _____
Date of Birth _____ Weight _____

Phone numbers (with area code):

Home Phone _____
Parent Cell phone #1 _____
Parent Cell Phone #2 _____

Non-Parental Emergency Contact (in case parent is unreachable):
Name and relation to hiker _____
Phone Number _____ E-mail _____

Please provide the following medical information so our Staff may give the best care possible. Use the back of this form for extensive descriptions when necessary.

Date of Last Tetanus Booster _____
Medication Taken Daily (including vitamins) frequency, time of day, and for what purpose

Allergies (Food, Environment, Medicines, etc.)

Special dietary/Nutritional needs

Past Medical Treatments

Any Physical/Mental/Psychological Conditions (please describe duration, treatment, and potential effects during WT Event)

Please check here if you carry your own Epinephrine-pen.
 Please check here if you self-administer Epinephrine-pen.

Dentist (name and phone number)

Primary Physician (name and phone number)

Insurance Company _____ Policy Number _____
Name of Insured _____ Insured Date of Birth _____

I give permission for _____ to be a part of the Wilderness Trail experience. I give permission for photographs of me or my child to be used in W.T. publicity, reports, and recruitment. I have read the above information and understand that there are many unknown perils and I release Wilderness Trail, staff and volunteers from liability resulting from any incidents. I or my child is in good health and can withstand the rigors of hiking. I also understand that to participate in Wilderness Trail activities I or my child must have had a tetanus booster in the past 10 years. In addition, I give my permission to the physician and/or Wilderness Trail servant leader for the period of the hike to arrange for routine or emergency medical/dental care and treatment necessary to preserve my health or the health of my child. I acknowledge that I am responsible for all charges in connection with care and treatment rendered during this period.

MUST BE SIGNED BY HIKER (AGE 18 OR OLDER) _____ DATE _____
OR RESPONSIBLE PARENT / GUARADIAN (IF UNDER 18)

WITNESS _____ DATE _____

SIGNATURE OF ATTENDING WT STAFF PERSON DATE

Parents of Minors: Please read this section carefully and check all that apply if you are sending **ANY** medication with your child.
 I am sending medication with my child: (list all) _____
 My child knows the proper dosage and use of these medicines and may **self-administer** them appropriately.
 I am sending the medication listed and desire **my child's leader to be responsible** that my child receives their medication at the proper times.

Signature of Parent/Guardian Date W.T. Servant Leader Assigned to Above Child Date