REQUIRED FOR ALL PARTICIPANTS

Registration Form

For Port Angeles School District Natural Resources Program

Please complete this entire form legibly and in ink. Be sure to sign where indicated.

The Port Angeles School District (PASD) Natural Resources Program leads field science classes in beautiful North Olympic Peninsula settings. Founded in 2008, PASD Natural Resources teaches field science and career skills to students from across the North Olympic Peninsula. Through the North Olympic Peninsula Skills Center, PASD Natural Resources serves five participating school districts: Port Angeles, Sequim, Crescent, Quileute Valley, and Cape Flattery.

PASD Natural Resources offers classes that incorporate Washington State Science and Career and Technical Education standards through a field-oriented, hands-on, project-based curriculum. PASD Natural Resources' highly-skilled teachers provide these educational adventures while adhering to the highest safety standards. All of our teachers hold a wilderness first responder certification and have completed specific trainings.

To help ensure that your child has the best experience, please take the time to complete and sign the entire form.

Participant Name _____, _____ **Date of Birth** _____
(first) (last)

☐Teacher/Para ☐Parent/Volunteer ☐Student Grade _____ ☐ Female or ☐ Male

Address _____ City/State/Zip _____

Email Address _____

Name of parent(s) or legal guardian _____, _____/ _____, _____
(first) (last) (first) (last)

Address (if not same as above)_____ City/State/Zip _____

EMERGENCY CONTACTS – ***parent or legal guardian must be provided as first emergency contact***

#1. Name _____ Relation_____Email_____

Day Phone _____Evening Phone _____ Cell Phone/Pager _____

#2. Name _____ Relation_____Email_____

Day Phone _____Evening Phone _____Cell Phone/Pager_____

PASD respects the privacy of the information provided by you. PASD will never sell or make available this information to other organizations. PASD reserves the right to use this information for internal marketing and development purposes. Participants can opt out of receiving information from PASD at any time.

Revised 9/2013

HEALTH INFORMATION: PLEASE FILL OUT COMPLETELY ∗DOCTOR SIGNATURE NOT REQUIRED

Do you have, or have you had, any of the following conditions or symptoms?

Current Medical Conditions			**Diseases**			
1. Bleeding/Clotting Disorders	☐Yes	☐No	11. Chicken Pox	☐Yes	☐No	If Participant Has Allergies:
2. Asthma	☐Yes	☐No	12. Measles	☐Yes	☐No	
3. Diabetes	☐Yes	☐No	13. Mumps	☐Yes	☐No	23. Do you carry own
4. Ear Infections	☐Yes	☐No	14. Other Diseases	☐Yes	☐No	Epi-pen? ☐Yes ☐No
5. Heart Defects/Hypertension	☐Yes	☐No	**Allergies**			
6. Psychiatric Treatment	☐Yes	☐No	15. Hay Fever	☐Yes	☐No	24. Do you carry own
7. Seizure Disorder	☐Yes	☐No	16. Iodine	☐Yes	☐No	Inhaler? ☐Yes ☐No
8. Immuno-Compromised	☐Yes	☐No	17. Poison Oak	☐Yes	☐No	
9. Hospitalized in the last 5 yrs?	☐Yes	☐No	18. Penicillin	☐Yes	☐No	Date of last Tetanus shot:
10. Other	☐Yes	☐No	19. Bees/Wasps/Insects	☐Yes	☐No	

If you have answered "yes" to any of the above items, please explain below. Provide corresponding number.

Question Number	Explanation

Health Questionnaire: **(Attach additional pages if necessary to provide complete information.)**

Is the participant taking any medication? ☐Yes ☐No Please list all medications** the participant is taking and the purpose of each.

_____

_____

****Please continue to take all medications as prescribed unless otherwise instructed by your physician.**

Is the participant capable of participating in a 5 mile hike? ☐Yes ☐No Are there any restrictions on the participant's physical activity? ☐Yes ☐No

Please describe _____

_____

Does the participant eat **red meat**? ☐Yes ☐No **Poultry**? ☐Yes ☐No **Fish**? ☐Yes ☐No

Does the participant have any **food allergies**? Please specify _____

Does the participant have any **food restrictions**? Please specify_____

Please provide any additional information that is important for us to know to insure the participant has a quality experience.

_____

_____

Name of Physician _____ Telephone Number _____

Medical Insurance carrier _____

Policy #/I.D.# _____ Subscriber Name_____

Additional information attached: ☐Yes ☐No

AUTHORIZATION FOR TREATMENT: PARENT/GUARDIAN MUST SIGN

I agree the above information is correct to the best of my knowledge, and I authorize any PASD Staff or volunteer to consent to any Xray, examination, anesthetic, diagnosis, treatment, and/or hospital care that may be recommended by a licensed physician and/or dentist. For minor illnesses or injuries, I understand that PASD will attempt to contact me at the earliest practicable opportunity. For major illnesses or injuries, PASD will attempt to contact me before the commencement of any medical treatment, unless my child's condition is such that treatment must be commenced immediately before contact with me can be made. Even if I cannot be reached, this authorization remains infull force and effect. I authorize PASD staff who have received appropriate training to (1) dispense "over the counter" medication, including aspirin, Tylenol, ibuprofen, Benedryl, Neosporin, Pepto-Bismol, and other similar medications; and (2) administer epinephrine via injection for the emergency treatment of anaphylactic shock that may result from an allergic reaction to insect bites, insect stings, food or plants (such as poison oak). This administration is under the direction of PASD's medical director. I agree to assume full financial responsibility for any medical care/treatment my child may receive.

****MUST SIGN****

Signature of Parent/Guardian_____Date:_____

Please Print Name of Participant: _____

REQUIRED FOR ALL PARTICIPANTS

ACKNOWLEDGEMENT AND ASSUMPTION OF RISKS – RELEASE AND INDEMNIFICATION

Definitions

I understand that the term **"PASD"** as used in this document means and includes Port Angeles School District, and each of their current and former officers, directors, employees, agents, contractors, and affiliated or related entities; the term "**PASD Staff**" means and includes any employee or agent of **PASD**; the term **"I"** means and includes any participant 18 years or older, or the parent or legal guardian of any participant who is younger than 18 years of age; and the term "**Program**" means PASD Natural Resources.

Acknowledgment and Assumption of Risks

I understand that during my participation in this Program, I may be exposed to a variety of risks and hazards, foreseen or unforeseen, which cannot be eliminated without fundamentally altering the unique character of the Program. These inherent risks include, but are not limited to, environmental risks and hazards, including rapidly moving, deep, or cold water; insects, snakes, and predators, including large animals; falling and rolling rock; lightning and unpredictable forces of nature, including weather that may change to extreme conditions without notice. Activities vary from program to program, and may include hiking on steep and uneven terrain, using field science equipment (eg: using water testing probes and tape measures in rivers and forests), ecosystem restoration activities (eg: plant removal and trail maintenance using shovels and picks), backpacking, or snowshoeing. Programs involve travel in PASD or other school district vehicles driven by PASD or other school district employees. Possible injuries and illnesses include hypothermia, frostbite, high altitude illnesses, sunburn, heatstroke, dehydration, and other mild or serious conditions or injuries. Emergency evacuations and medical care may be delayed due to the remote locations where Program activities take place. I understand that this description of the risks involved is not complete, and that other unknown or unanticipated risks may result in property loss, injury, or death. As a condition of my participation in the Program, I agree to assume full responsibility for all the risks that such participation may entail. My participation in this Program is entirely voluntary, and I elect to participate with full knowledge of the inherent risks.

Consent to Medical Treatment

I understand that if I become ill or injured during the course of the Program and am unable to give my consent to any medical treatment that a licensed physician and/or dentist deems necessary, PASD will make a reasonable attempt to obtain consent for treatment from the Emergency Contact(s),that I have provided, before such treatment is commenced, unless my condition is such that treatment cannot be delayed for that purpose. If treatment cannot be delayed, then I hereby consent to such treatment as a licensed physician or dentist determines is necessary.

Release and Indemnification

In consideration of my participation in the Program and the services and amenities provided by PASD, I VOLUNTARILY AGREE TO (1) RELEASE, DISCHARGE, AND HOLD HARMLESS PASD, TO THE FULLEST EXTENT PERMITTED BY LAW, FROM ANY AND ALL CLAIMS, DEMANDS, DAMAGES, LOSSES, OR LIABILITIES, INCLUDING, BUT NOT LIMITED TO, CLAIMS FOR PERSONAL INJURY OR DEATH, EVEN IF CAUSED BY THE NEGLIGENCE OF PASD (but not its willful or wanton misconduct), ARISING OUT OF OR IN ANY WAY CONNECTED TO THE PROGRAM OR MY PARTICIPATION IN THE PROGRAM; and (2) indemnify and defend PASD, to the fullest extent permitted by law, from and with respect to any and all claims, demands, liabilities, damages or costs, even if caused by the negligence of PASD (but not its willful or wanton misconduct), arising out of or in any way connected with the Program, or my participation in the Program, or occurring during the inclusive dates of my attendance at the Program, and/or from any medical treatment I may receive during the Program.

Other Provisions

PASD and persons designated by it may use my photograph, or any video, writing, artwork and/or testimonials created by me and submitted to PASD. It shall become the property of PASD, and may be used by PASD, at its discretion, for its own marketing and/or development purposes, and I hereby consent to and authorize such use without restriction.

Agreement

- I have had the opportunity to ask PASD any questions I may have about the Program in which I am enrolled, and any questions have been answered to my satisfaction.
- I understand that during some parts of the Program, I will be under the supervision of school district adult volunteers who are not PASD Staff. I understand these adults will undergo background checks by PASD.
- I understand that this document is intended by PASD to have as broad an effect as the law permits, and that if any part of this document is found to be invalid for any reason, the remainder of the document shall remain valid and fully enforceable.
- I have carefully read and I understand this entire document, and I am signing it voluntarily.

Signature

At least one parent or guardian must sign below if the student is under 18 years of age to reflect their understanding and agreement, for themselves and on behalf of the student, to the provisions of the definitions, acknowledgment and assumptions of risk, consent to medical treatment, release and indemnification, other provision, and agreement. Student may sign if 18 and own guardian.

_____ ____/____/____ ← ***** PLEASE SIGN+DATE HERE *****

Parent or Guardian Signature **Date**