Wilderness Trail, Inc.
www.wtrail.com

INFORMED CONSENT FORM
HEALTH INFORMATION AND PERMISSION TO TREAT

Please write in blue ink and bear down hard when writing.
One copy of this form is carried by the hiker in their back-pack, one copy is carried by the group leader, and one copy is retained by Wilderness Trail at the base camp (this copy is signed by attending Staff person upon arrival).
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 ensure safety, there are potential dangers inherent in any outdoor experience. These include falls, incidents with wildlife, exposure to communicable illness, lost hiker, bee and hornet stings, hypo/hyperthermia, illness related to unsafe water, and many others. Professional medical help is not always immediately available for emergencies. If needed, professional medical help will be summoned as quickly as possible by Staff. 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.

Participant Full Name _____

Parent / Guardian _____

Street Address _____

Mailing Address (if different) _____

City / State / Zip _____

WT Summer Events Completed _____ #WT Weekend Events Completed _____

Non-Parental Emergency Contact (in case parent/guardian is unreachable):
Name and relation to hiker _____
Phone _____ Email _____

Event # _____ Event Dates _____

Group / Church _____

Participant Email Address _____

Parent(s)/Family Email Address(es) _____

Date of Birth _____ Weight _____

Phone numbers (with area code):

Home Phone _____

Parent/Guardian Cell #1 _____

Parent/Guardian Cell #2 _____

Please provide the following medical information so that 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- frequency, time of day, and for what purpose (including vitamins)

_____

_____

Allergies (Food, Environment, Medicines, etc.)

_____

☐ Please check here if participant carries their own Epinephrine-pen.
☐ Please check here if participant self-administers Epinephrine-pen.

Dentist (name and phone number)

_____

Special Dietary/Nutritional Needs

_____

Any Past Medical Treatments

_____

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

_____

_____

Primary Physician (name and phone number)

_____

Health Insurance Information

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 dangers inherent in a wilderness experience. 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 the Wilderness Trail Staff for the duration 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) OR RESPONSIBLE PARENT / GUARDIAN (IF UNDER 18) DATE 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