

TETNUS IMMUNIZATION REQUIREMENT

IMMUNIZATION	REQUIREMENT	DATE OF LAST IMMUNIZATION
Tetanus	Within past 10 years	/ /

HOSPITALIZATION AND ILLNESSES (Within the past 2 years)

DATES / DURATION	REASON / DESCRIPTION

DIETARY RESTRICTIONS

PLEASE LIST ALL DIETARY RESTRICTIONS AND EXPLANATIONS BELOW:

ADDITIONAL INFORMATION

PLEASE DISCLOSE ANY OTHER MENTAL, PHYSICAL OR EMOTIONAL CONDITIONS OR LIMITATIONS THAT MAY AFFECT PARTICIPATION, NECESSITATE CARE, OR POTENTIALLY AFFECT THE HEALTH OR WELL-BEING OF PARTICIPANT OR OTHERS IN THE PROGRAM:

SUNSCREEN

PLEASE LIST ANY SPECIAL INSTRUCTIONS FOR ADMINISTERING SUNSCREEN TO MY CHILD:

HEALTH INSURANCE INFORMATION

PLEASE PROVIDE COMPANY, GROUP & POLICY NUMBER

VERIFICATION & AUTHORIZATIONS

I DECLARE THAT THESE STATEMENTS ARE COMPLETE AND CORRECT AND THAT I HAVE PROVIDED AVID4 ADVENTURE WITH ALL RELEVANT MEDICAL INFORMATION. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM AVID4 ADVENTURE OF ANY CHANGES, INCLUDING CONTACT INFORMATION.

SHOULD THE STAFF RECOGNIZE THE NEED TO APPLY SUNSCREEN TO MY CHILD, I AUTHORIZE THEM TO DO SO.

I HAVE SEEN AN OVERVIEW OF ACTIVITIES FOR THE PROGRAM IN WHICH I HAVE VOLUNTARILY ENROLLED MY CHILD. I GIVE PERMISSION FOR MY CHILD TO BE TRANSPORTED TO AND PARTICIPATE IN ALL OF THE SCHEDULED ACTIVITIES AND FIELD TRIPS, OR I HAVE DESIGNATED THE ACTIVITIES THAT I DO NOT WISH MY CHILD TO PARTICIPATE IN ON THE REGISTRATION DATA FORM.

IN THE EVENT THAT MY CHAILDIS INJURED IN AN ACCIDENT, OR BECOMES SERIOUSLY ILL, I HEREBY AUTHORIZE AVID4 ADVENTURE TO PROVIDE FIRST AID TO THE LEVEL OF THEIR TRAINING AND TO ARRANGE FOR THE TRANSPORTATION OF MY CHILD TO A LICENSED EMERGENCY MEDICAL CARE FACITLYT TO RECEIVE TREATMENT. FURTHERMORE, I AUTHORIZE THE MEDICAL PERSONNEL AT THE FACITLYT TO PROVIDE SUCH TREATMENT TO MY CHILD AS IS INDICATED BY THE NATURE AND EXTENT OF HIS OR HER INJURY AND THAT IS IN ACCORDANCE WITH THE PROTOCOLS OF STANDARD MEDICAL PRACTICE. FINALLY, I ACCEPT FINANCIAL RESPONSIBILTIY FOR ALL COSTS ASSOCIATED WITH THE CONVEYANCE OF MY CHILD AND FOR THE TREATMENT PROVIDED BY THE MEDICAL CARE FACITLIY TO MY CHILD.

ENROLLMENT IS INCOMPLETE UNTIL PARENTS OR GUARDIANS SIGN BELOW.			
	SIGNATURE	DATE	PRINTED NAME
Parent/Guardian Signature			
Parent/Guardian Signature			