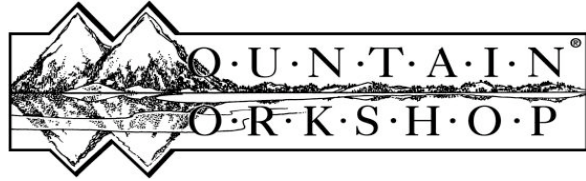


THE MOUNTAIN WORKSHOP
 A Division of Hawke Mountain Ventures, LLC
 9 Brookside Place
 West Redding, CT 06896
 Phone (203) 544-0555 Fax (203) 544-0333
 www.mountainworkshop.com



HEALTH INFORMATION AND RELEASE – 2010
To be completed by parent or guardian
 Please read, sign, and complete BOTH pages.

Must be returned by May 1st, 2010

This signed form is required for participation in a Mountain Workshop program.

First Program Name _____	Date _____	Session # _____	Location _____
Second Program Name _____	Date _____	Session # _____	Location _____

PARTICIPANT			
Name _____	Home Phone _____	Date of Birth _____	Age on program _____
Address _____		City _____	State _____ Zip _____
PARENTS OR GUARDIANS			
Name _____	Home Phone _____	Work Phone _____	Cell Phone _____
Name _____	Home Phone _____	Work Phone _____	Cell Phone _____
EMERGENCY CONTACT (If a parent/guardian is not available in an emergency)			
Name _____	Relationship _____		
Phone (Day) _____	Phone (Evening) _____		
In what order would you like us to contact you? _____			
DOCTOR	Name _____	Phone _____	
DENTIST	Name _____	Phone _____	
INSURANCE CARRIER	_____	Policy # _____	Date of Last Physical Exam _____

In case of Medical Emergency, I understand that every reasonable effort will be made to contact the parent or guardian of this child. In the event I cannot be reached, or if the attending physician or health care provider believes that immediate medical care without delay is required or appropriate, I hereby give permission to the physician or health care provider selected by The Mountain Workshop trip leader to secure medical treatment, hospitalization, secure anesthesia, and/or to order or consent to injection, surgery or medication for my child named above. I understand that The Mountain Workshop, and any such health care provider will be relying on my completing and signing this form.

I understand that, as a parent or guardian, I must assume all medical obligations of my child in the event of an injury or illness while he/she is in custody of The Mountain Workshop. To the best of my knowledge, my child is capable mentally and physically of participating in this program.

 Parent's/Guardian's Signature

 Print Name

 Date

Don't forget to fill out the back . . .

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Health Information and Release (cont.)

(page 2 – to be completed by parent or guardian)

PARTICIPANT _____

Medications must be sent in original container labeled with child's name and prescribed dosage.

1. Yes No **Will your child be using any medications?**

If yes, please identify and explain. If your child is taking any medication (prescription or over-the-counter) while on a Mountain Workshop program, please complete an "Authorization for Administration of Medication" form. This form must be completed by both parent and physician, and is required for all prescription or over-the-counter medication.

NOTE: Please check the dates on all prescription drugs and inhalers before sending them on a program.

2. Yes No **Does your child have any allergic reactions to any medications, food, insect stings or injections?**

If yes, please explain _____

3. Yes No **Does your child have any condition now requiring medical attention or regular medication?**

If yes, please explain _____

4. Yes No **Does your child have any condition restricting his/her activity?**

If yes, please explain _____

5. Yes No **Are there any issues we should know about in order to meet the needs of your child and his/her group?**

If yes, please explain _____