

# Wolf Tree Programs

P.O. Box 44, Montague, MA 01351 (413) 210-9361  
wolftreeprograms1@yahoo.com

## **Registration Form** (Please print in ink)

**Session(s):** \_\_\_\_\_

**Cost: \$400 per session (\$100 deposit required to reserve space)**

Make Checks Payable to: Wolf Tree Programs

Participant's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Nickname \_\_\_\_\_ Gender  Male  Female Age on First Day of Program \_\_\_\_\_

Participant's Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Address (continued) \_\_\_\_\_ Email \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Present School \_\_\_\_\_ Grade \_\_\_\_\_

Siblings' Names and Ages \_\_\_\_\_

Participant lives with  Mother  Father  Both  Other \_\_\_\_\_

**Legal Guardian 1:** Name \_\_\_\_\_  mother  father  other \_\_\_\_\_

Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_

**Legal Guardian 2:** Name \_\_\_\_\_  mother  father  other \_\_\_\_\_

Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_

**Other Important Caregiver** Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Billing Address (if different) \_\_\_\_\_

How did you learn about the Wolf Tree Summer Day Camp?  Friend  Web  Class Trip  Other

Please Give Details on

Above \_\_\_\_\_

Emergency Contact Information

Wolf Tree Summer Day Camp Registration

Child's Name: \_\_\_\_\_ Start Date: \_\_\_\_\_

**REQUIRED SIGNATURES**  
**VERY IMPORTANT! PLEASE READ THIS PAGE CAREFULLY.**

**PHOTO RELEASE:** By signing below I hereby grant free permission for Wolf Tree Programs to use images of enrolled participant in their programs or events for outreach purposes, including but not limited to electronic or printed materials or media. Please consider granting this release to us if at all possible, as our ability to successfully share our program with new participants depends on having representative photographs.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**NO, I do not wish to grant a photo release.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

At Wolf Tree Programs, the safety of each camper is our highest priority. We take all reasonable precautions to ensure your child's physical and emotional safety and to provide a quality camping experience that focuses on fun, safety and character development. However, as in any other experience, we cannot eliminate all risk from our programs. By signing the following statements you will be acknowledging that you understand the risks of attending this program, assuming liability for your child's participation and certifying that your application is complete and truthful.

**Acknowledgement of Risk**

I understand that the program takes place in rocky, mountainous and forested terrain and that water activities are a part of the experience. The following potentially hazardous activities, as well as others not mentioned, may be undertaken: camping, building natural shelters, hiking, wading, cooking, fire building, use of tools, & use of knives. These activities can cause personal injury, property damage, illness or death.

\_\_\_\_\_  
Parent/Guardian signature

\_\_\_\_\_  
Date

**Assumption of Liability**

In recognition of the potential hazards, I, or my children, my heirs and assigned, do hereby release Neill Bovaird and his employees, agents, volunteers, program participants and anyone else acting in any capacity on their behalf (hereinafter, collectively referred to as "Wolf Tree Programs") from any and all liability, actions, causes of action, debts, claims and demands of every kind and nature whatsoever, and specifically including any claim for negligence or negligent acts, arising from my child's participation in a Wolf Tree Programs program. I further agree to hold harmless and indemnify Wolf Tree Programs and its agents for all defense costs, including my attorney's fees and any other costs resulting in connection with my child's participation.

\_\_\_\_\_  
Parent/Guardian signature

\_\_\_\_\_  
Date

**Statement of completeness**

All of the information on this Participant Application form is confidential and will only be shared with the appropriate Wolf Tree Programs staff. Participants with a variety of medical/psychological/physical conditions or problems have successfully participated in our programs but WE MUST BE AWARE OF THESE CONDITIONS. Other Participants, staff, and the applicant are all put at risk when this information is withheld.

I understand that if my child arrives at camp with a pre-existing condition, injury or other health problem not indicated on this application which Wolf Tree Program staff discovers because of its negative impact on my child's experience, fellow campers, staff, or the camp program, my child may be asked to leave the program s/he is attending and I will receive no refund of tuition. I hereby certify that I have answered all questions on this application and the parent questionnaire truthfully and completely. If circumstances change between today and the first day of the program so that this application is no longer truthful or complete I certify that I will fully inform Wolf Tree Programs of the new circumstances.

\_\_\_\_\_  
Parent/Guardian signature

\_\_\_\_\_  
Date

## Wolf Tree Programs Day Camp Health Exam/Record

### For Campers and Staff

Physical Exams are Valid for 2 Years  
From Date of Last Examination

**Please Return Completed Form to the Camp**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_  
 Guardian \_\_\_\_\_ Address \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Telephone \_\_\_\_\_  
 Date of Arrival at Camp: \_\_\_\_\_ Departure Date: \_\_\_\_\_

.....  
**TO BE COMPLETED BY THE SPECIFIED MEDICAL PARCTITIONER:**

**Date of Exam** \_\_\_/\_\_\_/\_\_\_

\_\_\_ May participate in all camp activities  
 \_\_\_ May participate except for: \_\_\_\_\_  
 \_\_\_\_\_

Medical information pertinent to routine care and emergencies: \_\_\_\_\_  
 \_\_\_\_\_

Is this individual taking prescription or over the counter medication(s)? YES NO If yes, indicate names of Medication(s): \_\_\_\_\_  
 \_\_\_\_\_

Does the individual have allergies? YES NO Explain: \_\_\_\_\_  
 Is the individual on a special diet? YES NO Explain: \_\_\_\_\_  
 Does the individual have special needs? YES NO Explain: \_\_\_\_\_

This camper/staff is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	YES	NO		YES	NO
Measles			Hepatitis		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Polio		
Tetanus					

**Comments:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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Print name of medical care provider: \_\_\_\_\_

Medical care provider's address: \_\_\_\_\_

Medical care provider's: City/Town \_\_\_\_\_ ST \_\_\_\_ Zip Code \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician, PA, APRN, RN

\_\_\_\_\_  
Date form signed

\_\_\_\_\_  
Telephone Number

**Authorization for the Self-Administration of Medication While Attending Wolf Tree Programs**

Parent/guardians requesting to be self-administered by their child while at camp shall provide the program with appropriate written authorization and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name or medication, directions for medication's administration and date of the prescription. All unused medication will be destroyed if not picked up within one week following the camper's departure at the end of camp.

**AUTHORIZED PRESCRIBER'S ORDER** (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Medication Name \_\_\_\_\_ Controlled Drug? Yes No

Dosage \_\_\_\_\_ Method \_\_\_\_\_ Time of Administration \_\_\_\_\_

**Specific Instructions for Medication Self-Administration**

Medication Administration: Start Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Stop Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Relevant Side Effects of Medication \_\_\_\_\_

Plan of Management for Side Effects \_\_\_\_\_

Known Food or Drug: Allergies? Yes No Reactions to? Yes No NO interactions with? Yes No

If "yes" to any of the above, please explain \_\_\_\_\_

Prescriber's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Prescriber's Address \_\_\_\_\_ Town \_\_\_\_\_ ST \_\_\_\_\_

Prescriber's Signature \_\_\_\_\_

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**Parent/Guardian Authorization:**

I request that medication be self-administered by my child as described and directed above.

Name of Camp \_\_\_\_\_ Today's Date \_\_\_/\_\_\_/\_\_\_

Child's Name \_\_\_\_\_ Address \_\_\_\_\_ Town \_\_\_\_\_

Name of Parent/Guardian Authorizing Self-Administration of Medication \_\_\_\_\_

Relationship to Child: Mother    Father    Guardian/Other explain: \_\_\_\_\_

Address \_\_\_\_\_ Town \_\_\_\_\_ Phone # \_\_\_\_\_

\_\_\_\_\_  
**Signature of Parent/Guardian Authorizing Self-Administration of Medication**                      **Date**

**Name of Camp Personnel Receiving Written Authorization and Medication** \_\_\_\_\_

**Title/Position** \_\_\_\_\_ **Signature (in ink)** \_\_\_\_\_