FAMILY CAMP WOLF RIDGE
HEALTH, LIBALITY & INFORMATION FORM

WOLF RIDGE ENVIRONMENTAL LEARNING CENTER

Please complete the following form and mail it back to Wolf Ridge at least 3 weeks in advance of your program.

DATES ATTENDING

PLEASE WRITE THE DATES YOU WILL BE ATTENDING

PARTICIPANT NAMES & AGES

NAME OF PARTICIPANT_____ AGE _____
NAME OF PARTICIPANT_____ AGE _____
NAME OF PARTICIPANT_____ AGE _____
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NAME OF PARTICIPANT_____ AGE _____
NAME OF PARTICIPANT_____ AGE _____
NAME OF PARTICIPANT_____ AGE _____
NAME OF PARTICIPANT_____ AGE _____

PARTICIPANT HOUSEHOLDS

ARE THERE ANY PARTICIPANTS ATTENDING FAMILY CAMP WITH YOU OR YOUR FAMILY THAT DO NOT LIVE IN YOUR HOUSEHOLD?

☐ YES
☐ NO

If YES, please complete the following information.

NAME OF PARTICIPANT _____
PARENT/GUARDIANS _____
RELATIONSHIP TO FAMILY _____ AGE _____
ADDRESS _____
CITY _____ STATE _____ ZIPCODE _____
PARENT/GUARDIAN PHONE NUMBER _____

NAME OF PARTICIPANT _____
PARENT/GUARDIANS _____
RELATIONSHIP TO FAMILY _____ AGE _____
ADDRESS _____
CITY _____ STATE _____ ZIPCODE _____
PARENT/GUARDIAN PHONE NUMBER _____

If you need more space, please attach extra sheets

EMERGENCY CONTACT

NAME _____ RELATIONSHIP_____
DAY PHONE_____ EVENING PHONE_____CELL _____

PLEASE READ AND COMPLETE ALL SIDES

DIETARY RESTRICTIONS & PREFERENCES

INFORMATION WILL BE USED TO ALERT OUR KITCHEN STAFF TO ALLERGIES & DIETARY RESTRICTIONS
(please check which of the following pertain to you)

NAME ______________________________
- ☐ No Dietary Concerns
- ☐ Vegetarian
- ☐ Vegan
- ☐ Gluten Free
- ☐ Other Allergies or Dietary Restrictions

NAME ______________________________
- ☐ No Dietary Concerns
- ☐ Vegetarian
- ☐ Vegan
- ☐ Gluten Free
- ☐ Other Allergies or Dietary Restrictions

NAME ______________________________
- ☐ No Dietary Concerns
- ☐ Vegetarian
- ☐ Vegan
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- ☐ Vegan
- ☐ Gluten Free
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- ☐ Vegetarian
- ☐ Vegan
- ☐ Gluten Free
- ☐ Other Allergies or Dietary Restrictions

MEDICAL CONCERNS

MEDICAL INFORMATION: Please list below any participants and health conditions or special circumstances we should know about for any of the family/party members you listed above. Please describe any environmental allergies, the allergic reaction and how it is treated. (i.e. Bee stings, heat stroke, etc)

INSURANCE & EMERGENCY BILLING INFORMATION

Usually, there is no charge for first aid care given at Wolf Ridge by staff members of Wolf Ridge. However, you are financially responsible for health care given by other health care providers such as clinics & hospitals. Please provide the following information for use in case of emergency.

NAME OF INSURANCE COMPANY _____
(Please write "none" if you have no insurance)

POLICY HOLDERS NAME_____

GROUP #_____ POLICY #_____

PHYSICIAN _____ PHONE _____

FAMILY INFORMATION & SPECIAL EVENTS

FAMILY E-MAIL ADDRESS (if you have one) _____

If there are other families attending this program that you would like to room near, please list them below

Is your family celebrating an important event during this program? (birthday, anniversary, etc) If so, what is it?

RISK & LIABILITY

PLEASE READ AND SIGN BELOW. SIGNATURE REQUIRED FOR PARTICIPATION

As a representative for my family/party, I am aware that this program involves certain risks, which I accept for all family/party members listed on the previous page. These risks may include, but are not limited to, being transported by van to certain activities, walking on rugged trails in various weather conditions, canoeing, rock climbing and belaying indoors, and participating on a high ropes course. In the event of an emergency and the absence of an adult in our party, I authorize treatment by emergency medical personnel. I understand that I am financially responsible for all medical charges incurred on behalf of myself or my dependents. I authorize the health care provider to release all information needed to secure payment of benefits, and I authorize the use of this signature on all insurance claims for myself and/or my dependent. I hereby release Wolf Ridge, all of their personnel, agents, affiliates, staff and directors, from all liabilities to me with respect to injury, sickness, disease, loss or damage. This release does not apply to liabilities arising from gross negligence or wanton or reckless conduct by anyone, including Wolf Ridge or their representatives. Apart from that exception, it applies to all liabilities, to me or my estate of any description, whether arising from ordinary negligence or otherwise, and whether involving fees and expenses of any kind. In the event that some other entity seeks compensation for these released liabilities, I or my estate will indemnify and hold harmless Wolf Ridge for all sums reasonably incurred in response to that claim. This release is to be interpreted and enforced under Minnesota law.

_____ (PLEASE INITIAL) I authorize Wolf Ridge to use any photos taken during the program and comments made on evaluations by participants in publicity materials for Wolf Ridge.

Family Representative Signature _____ Date_____

PLEASE READ AND COMPLETE ALL SIDES

Please complete this form and mail it back to Wolf Ridge 3 weeks prior to your session.

Mail to
Wolf Ridge ELC
6282 Cranberry Road
Finland, MN 55603

Fax or email
mail@wolf-ridge.org
218-353-7762