

PIONEER TREK *SAMPLE* REGISTRATION FORM

Trek Date: _____ Stake: _____

.....
This form (2 pages) must be completed, signed in both places, and returned to your ward coordinator by _____. Each participant (*adult and youth*) must complete a form. Ward leaders must turn forms in to the Stake by _____.

Name: _____ Sex: ____ Age: ____ Birth date: _____

Address: _____, _____ Stake, Utah

Height: _____ Weight: _____

Insurance Company: _____ Policy #: _____

Parents' Name (if minor): _____ Phone: _____ Work: _____

.....
CONTRACT and RELEASE

1. I understand this Pioneer Trek 200__ will be held in a primitive wilderness setting. I also understand although we will be "roughing it", so to speak, that the Stake will provide food, restroom facilities, and safe drinking water.
2. I am voluntarily a participant in this Trek and I will accept full responsibility for my actions under all conditions. I also agree to aid other members of the group in behaving responsibly.

I understand and appreciate that there are inherent risks involved in this Stake-sponsored Trek which are beyond the control of the Stake staff and Ward leaders, and I agree to personally assume such risks. Also, the Stake staff and Ward leaders cannot be held responsible for any injuries or expenses, costs and/or claims in connection with any injuries sustained which were not directly caused by their failure to take due care. I hereby also agree to release the Farmington Utah Stake and its staff and Ward leaders from any and all claims for liability arising from my participation in the Pioneer Trek 200__.

I agree to abide by LDS standards. This means high standards of behavior, honor and integrity; and abstinence from alcohol, tobacco and harmful drugs are required of me and every participant involved in this Trek.

I (*and/or my guardian*) agree to accept full responsibility for any medical or related expense incurred which are not covered by my own insurance policy. Medical and dental benefits from the Church Activity Insurance Program may be available, but they are secondary to other insurance coverage and subject to limitations. Contact your bishop or branch president for plan coverage or a benefit claim form in case of an accident.

Health History

If you currently suffer from, or have experienced any of the following conditions within the past year, please mark the appropriate space below:

- | | |
|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Asthma (serious case) | <input type="checkbox"/> Major operation or serious illness |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart trouble |
| <input type="checkbox"/> Emotional problems requiring medication | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Ulcers medication | <input type="checkbox"/> Other medical conditions which might be aggravated by hiking |
| <input type="checkbox"/> Rheumatic fever | |
| <input type="checkbox"/> Major bone or joint injuries | |

Explain: _____

If you marked any of the above items, you must fill out a Medical Release Form and have it completed by a medical doctor; you cannot participate without it. The Medical Release Form is available from your ward coordinator.

Describe any allergies or medication reactions:

Medications currently being used: _____

Have you had more than a minor illness or injury during the past year? Yes No

If yes, please explain:

Family Doctor: _____ Phone: _____

I agree to the above terms and declare the above statements are complete and correct.

(Date)

(Signature of Participant)

As a parent, I am aware that my child will be participating in Pioneer Trek 200__. I have read the Contract and Release and the completed health history, and I am aware of the circumstances my child will undergo, and I hereby give my full permission for him/her to participate. Also, in the event any medical attention is needed, I hereby authorize any leaders to seek medical treatment and medical personal in charge of my child to administer such medical or surgical treatment or carry out such procedure as may be deemed necessary or advisable in the diagnosis or treatment of my child.

I agree to the terms of the Contract and Release and declare the above statements are complete and correct.

(Date)

(Signature of Parent/Guardian)

*(Parent or guardian must sign here if participant is under 18 years of age.
Participants 18 or older must sign here--for themselves)*

SAMPLE REGISTRATION AND MEDICAL FORM

Ward: _____

This form (2 sides) must be completed, signed in both places, and returned by **Date** to ward leaders. Each participant (adult and youth) must complete a form.

Name: _____ Sex: ____ Age: ____ Birth date: _____

Address: _____ Phone: _____

Insurance Company: _____ Policy #: _____

Parent's Name (if minor): _____ Work Phone: _____

Parent's Name (if minor): _____ Work Phone: _____

Please list any other required information that may be needed for insurance purposes if it becomes necessary to secure the medical services of a doctor or hospital. This could include insurance pre-authorization phone numbers, name and Social Security number of the insured employee, whether it is necessary to contact a primary care physician, etc. **Note:** Parents of youth will be contacted, if at all possible, before securing the medical services of a doctor or hospital in the case of an emergency.

Information: _____

Statement of Responsibility

This Pioneer Trek Youth Conference will be held in a wilderness setting. We will be “roughing it”, so to speak. The Stake will provide food, restroom facilities, safe drinking water, and learning activities. Each participant in this conference must act in accordance with church standards at all times, and aid other members of the conference in behaving in accordance with church standards. There are inherent risks involved in all outdoor activities, including this Stake sponsored Youth Conference, which are beyond the control of the Stake staff and officers. Proper preparation reduces these risks and is the responsibility of all participants. These considerations should include a warm sleeping bag, warm clothing, a poncho or rain coat, sunscreen, insect repellent, and other items listed on the personal equipment list. All participants must act in such a way as to not endanger themselves or others, and should show charitable consideration to all other participants and leaders in the Trek.

Each participant should condition themselves physically for this experience. Specifically, each participant must be able to complete a *minimum* requirement of walking/running four(4) miles on level ground in 60 minutes or less without undue stress.

The Trek will be conducted on private property. Each participant must follow applicable “No Trace Camping” protocols to maintain the wilderness nature of the property. Especially, each participant must avoid littering of any kind.

Sample Medical History

If you currently suffer from, or have experienced any of the following conditions within the past year, please mark the appropriate space below:

- | | |
|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Asthma (serious case) | <input type="checkbox"/> Major operation or serious illness |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart trouble |
| <input type="checkbox"/> Emotional problems requiring medication | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Other medical conditions which might be aggravated by hiking |
| <input type="checkbox"/> Rheumatic fever | |
| <input type="checkbox"/> Major bone or joint injuries | |

Explain: _____

If you marked any of the above items, you must fill out the Medical Release Form and have it completed by a medical doctor; **you cannot participate without it.** The Medical Release Form is available from your ward YM or YW secretaries.

Allergies, special diets, or medication reactions: _____

Medications currently being used: _____

Are immunizations up to date (especially tetanus shot)? _____

Physical conditions that limit activity: _____

Have you had more than a minor illness or injury during the year, or a chronic/recurring illness? _____

If yes, please explain: _____

Family Doctor: _____ Phone: _____

Participant Agreement

I declare that the above statements are complete and correct, and agree to act in accordance with the Statement of Responsibility.

Date: _____ Signature of Parent: _____

Parental Permission

I, the undersigned, am aware that my youth will be participating in the above designated Stake Pioneer Trek Youth Conference. I have read the Statement of Responsibility and have supplied the medical statements above, which are complete and correct. I hereby give my full permission for him/her to participate in this youth conference and authorize the adult leaders supervising this activity to administer emergency treatment for any accident or illness and to act in my stead in approving necessary medical care. In the even any medical attention is needed. I hereby authorize any physicians in charge of my child to administer such medical or surgical treatment or carry out such procedure as may be deemed necessary or advisable in the diagnosis or treatment of my child. This permission includes travel to and from the conference as well as participation at the conference.

Date: _____ Signature of Parent: _____

SAMPLE MEDICAL RELEASE FORM

This form must be completed and signed by a medical doctor for participants who answered "yes" to any of the conditions listed on the Medical History portion of the Registration form. They will not be allowed to participate if this form is not submitted. The examination must be current within six weeks of the participation date.

Participant: _____ Date of Conference: _____

Dear Doctor: The above named person will participate in a Pioneer Youth Conference. Persons suffering from any of the conditions listed below must obtain a physician's clearance before participating in this program. The participants will be in a wilderness setting for four days. They will have ample food and water. On the **first day** they will hike approximately 10 to 14 miles on varying terrain. On subsequent days they will hike approximately 2 to 5 miles on varying terrain and engage in other outdoor activities. Please consider the following conditions in your decision (as well as other medical problems which may be aggravated by or interfere with the aforementioned conditions):

If you currently suffer from, or have experienced any of the following conditions within the past year, please mark the appropriate space below:

- | | |
|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Asthma (serious case) | <input type="checkbox"/> Major operation or serious illness |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart trouble |
| <input type="checkbox"/> Emotional problems requiring medication | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Ulcers medication | <input type="checkbox"/> Other medical conditions which might be aggravated by hiking |
| <input type="checkbox"/> Rheumatic fever | |
| <input type="checkbox"/> Major bone or joint injuries | |

Explain: _____

Due to the strenuous physical nature of Pioneer Trek Youth Conference, individuals suffering from aggravating medical conditions are not to be allowed to participate in some of the regular **first day's** activities. However, these individuals still need your approval to participate in subsequent outdoor activities and hiking where medical facilities are limited.

Individuals will be allowed to take medications for chronic conditions if the medication is prescribed or accompanied by a doctor's approval.

General Appraisal:

- APPROVAL: I find no medical problems which I consider incompatible with this program.
- LIMITED APPROVAL: This individual may participate subject to the limitations listed below.
- DISAPPROVAL: This individual has medical problems which, in my opinion, clearly constitute unacceptable hazards to his/her health and safety in this program.

Recommendations and/or restrictions: (if none, specify) _____

Date: _____ Signature: _____

Doctor's Name (print): _____ Phone: _____

Address: _____