



Readington Township Recreation
And
The Children of the Earth Foundation

PROGRAM NAME Nature and Wilderness Survival Series **DATES** _____

FAMILY INFORMATION

Last Name(s) _____ (please list all if more than one applies)

Home Address _____

City _____ State _____ Zip _____ Country _____

Home Phone _____ Email _____

PARTICIPANT INFORMATION (Please complete for each family member who will be attending.)

Name (if not the parent/guardian, please indicate your relationship to minor participants)	Gender (please circle)	Age (at the time of camp. Adults just indicate "adult")
	M F	
	M F	
	M F	
	M F	
	M F	
	M F	

CONTACT INFORMATION

1) Parent/Guardian Name _____ Cell Phone () _____

Work Phone () _____ Work Email _____

2) Parent/Guardian Name _____ Cell Phone () _____

Work Phone () _____ Work Email _____

3) Emergency Contact _____ Relationship _____

Home Phone () _____ Cell Phone () _____

Work Phone () _____ Email _____

MEDICAL FORM
(must complete for each participant)

Name _____ Date of Birth _____

Primary Physician _____ Phone (____) _____

Medical Insurance Company _____ Policy Number _____

Medical History

Please list any:

Allergies to Food(s): _____

Allergies to Medication(s): _____

Other Allergies: _____

Describe reaction and treatment of these allergies: _____

Please check all that apply to the participant:

_____ Recent injury or illness

_____ Have asthma

_____ Chronic or recurring illness/condition

_____ History of sleepwalking

_____ Frequent headaches

_____ History of bed-wetting

_____ Wear glasses or contacts

_____ Eating disorder

_____ Frequent ear infections

_____ Diagnosed with ADD or ADHD

_____ Ever had seizures

_____ Emotional/psychological difficulties for
which professional help was sought

_____ Ever had high blood pressure

_____ Other medical conditions

_____ Have diabetes

Please explain all items that are checked or any other issues for which you would like us to be aware:

Medications: Please list ALL medications, including nonprescription drugs that will be taken at program.

Please bring enough medication to the last the entire time at camp and keep it in the original packaging.

Medication 1 _____ Dosage _____ For _____

Specific time(s) take each day or condition _____

Medication 2 _____ Dosage _____ For _____

Specific time(s) take each day or condition _____

Medication 3 _____ Dosage _____ For _____

Specific time(s) take each day or condition _____

If person is a minor attending without adult:

I give permission for Children of the Earth Foundation personnel to administer these medications as indicated above:

Signature of Parent/Guardian _____

Dietary: Please indicate any special dietary need:

Vegetarian

Vegan

Other: _____

CONDITIONS OF PARTICIPATION

RELEASE AND WAIVER OF LIABILITY: In all programs conducted by The Children of the Earth Foundation (hereinafter COTEF), reasonable care is taken to prevent serious injuries and to minimize accidents. I am fully aware that survival, tracking, awareness and philosophy training, even under the safest conditions, has inherent dangers and I hereby accept any and all responsibility for, and assume the risk of any and all injury or damage to my person or dependant children that might arise directly or indirectly as a result of participation in any COTEF program. I hereby expressly release, discharge and hold harmless from any liability whatsoever, COTEF and all employees and volunteers in their capacity as representatives of COTEF, expressly including the Board of Directors of the COTEF, except for injuries caused intentionally, or by willful misconduct.

PROPERTY LOSS: I understand COTEF is not responsible for a participant's personal property that is lost, damaged or stolen during the course of a COTEF program.

INSURANCE: I understand that it is my responsibility to provide for my own, and any other members of my family if applicable, accident and health coverage while participating in COTEF programs. COTEF does not provide any accident and health insurance for its participants.

MEDICAL RELEASE: I authorize COTEF, as my agent, to give consent to surgical or medical treatment by a licensed physician or hospital when the physician deems such treatment necessary and I cannot be contacted within a reasonable time or I am not otherwise able to give such consent. I authorize COTEF to give first aid, CPR or other treatment by a qualified staff member.

PHOTGRAPHS: I authorize COTEF to have and use photographs or video of my child/ren or myself as may be needed for its records or public relations projects.

ACCEPTANCE: I certify that I am familiar with the contents of this release, that I have read and understand the same, and that it is my intention by signing this release that the same be binding not only on me, but on my heirs, administrators, executors, successors, and assigns.

Signature of all adult participants and/or parent/guardian of minor participants:

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____



Send Registration to:

Amy Manning
2150 Amwell Road
Somerset, NJ 08873
Fax: 609-397-0112

For more information, contact Amy Manning at
908-310-9064 or amy.manning07@gmail.com