Assumption of Risk and Release of Liability Form

PLEASE READ THIS AGREEMENT CAREFULLY. IT IS A LEGAL CONTRACT AND AFFECTS ANY RIGHTS YOU MAY HAVE IF YOU ARE INJURED OR OTHERWISE SUFFER DAMAGES WHILE PARTICIPATING IN THIS ACTIVITY.

The undersigned has been made aware that during participation in Project WILD activities, certain dangers and exposure to physical injuries will be present, including but not limited to: hazards of changes in temperature and climate, travel in natural wooded areas, including the Project WILD Ropes Course area, contact with wild animals, reptiles, insects, and poisonous plants, and travel to, from, and around Pisgah National Forest. I understand that participation requires physical exertion and I am willing to assume the risks involved in this activity. In order to avoid these risks as best possible, participants are advised to follow specific directions given from Project WILD staff.

In consideration of and as a condition of the right to participate in such an adventure/ community/ team building experience, or other activities and services incident thereto, arranged by Project WILD and Duke University, the undersigned does hereby assume all risks incident to such activities and does hereby release and discharge Project WILD and Duke University, as well as any of its agents and employees or representatives, and other person or organization whose acts or to whom Project WILD and Duke University might be liable, from any and all liabilities, actions, causes of action, debts, claims, demands of whatsoever kind and nature which may arise out of or in conjunction with such an adventure experience or participant in any activities incident thereto.

I have carefully read this Assumption of Risk and Release and fully understand its contents. I voluntary sign it and realize that it will bind my heirs, personal representatives, and me.

___________________________________ (Participant's Signature)

_______________________(Date)

_____________________________ (Please print your name)

The undersigned, as parents or guardian of the above designated Project WILD program participant, who is under the age of 18 years, do hereby join in the execution of this document and agree to be bound by all the terms and conditions thereof.

___________________________________ (Parent's/Guardian's Signature)

_______________________(Date)

_____________________________ (Please print your name)

NAME: ______________________________

PROJECT W.I.L.D. MEDICAL HISTORY FORM

All information on this form is kept confidential. Only a medical reviewer and appropriate Project W.I.L.D. staff will review it. For your safety, please ensure all information on this form is accurate and complete. Medical conditions do not automatically disqualify you from participation and we will try to accommodate any medical conditions or restrictions you have. Project W.I.L.D. reserves the right to refuse admission to anyone medically unfit for the program's activities. If you answer "yes" to a critical medical question, your medical provider must review your condition and clear you to participate. If you do not answer "yes" to any critical medical questions no review is necessary. Write legibly in ink.

Personal Info:

Name:____ Date of Birth: ____/____/_____
Address: _______________________________________City: _______________________ State: ____ Zip: _________
Country: ___________________________ Gender: Male / Female (circle) Primary phone: (______) ______-________

General Medical Information (to be completed by the participant):

Do you regularly take any medications? (list on next page and bring on trip) No: ___ Yes (elaborate next page): ___
Do you have any allergies or adverse reactions to any medications? No: ___ Yes (elaborate next page): ___
Have you ever had an allergic reaction to a bee sting or insect bite? No: ___ Yes (elaborate next page): ___
Do you have asthma? No: ___ Yes (elaborate next page): ___
Do you have a prescribed inhaler? (describe on next page and bring on trip) No: ___ Yes (elaborate next page): ___
Do you have any concerns that we or emergency personnel should be aware of? No: ___ Yes (elaborate next page): ___
Are you currently undergoing treatment for any medical condition? No: ___ Yes (elaborate next page): ___

Dietary Restrictions (to be completed by the participant):

Are you vegetarian or vegan? No: ___ Yes (elaborate next page): ___
Other than vegetarianism, do you have any dietary restrictions? No: ___ Yes (elaborate next page): ___
Do you have any food-related allergies? No: ___ Yes (elaborate next page): ___
Have you used iodized water before? (we disinfect water with iodine) No: ___ Yes (elaborate next page): ___
Have you had any complications or reactions associated with the use of iodine? No: ___ Yes (elaborate next page): ___

Critical Medical Information (to be completed by the participant):

For any "yes" answers in this section, the medical/surgical provider who treated you or your personal medical provider must review these medical conditions, clear you to participate, and sign below.

Have you ever had a severe allergic reaction requiring medical attention? No: ___ Yes (elaborate next page): ___
Have you had surgery in the past 12 months? No: ___ Yes (elaborate next page): ___
Have you required hospitalization in the past 12 months? Why? No: ___ Yes (elaborate next page): ___
Have you ever required hospitalization for an issue related to mental health? No: ___ Yes (elaborate next page): ___
Do you have any spine or back injuries or ankylosing spondylitis? No: ___ Yes (elaborate next page): ___
Do you have any orthopedic injuries or joint injuries? No: ___ Yes (elaborate next page): ___
Do you have any chronic or progressive illnesses? No: ___ Yes (elaborate next page): ___
Do you have any respiratory illnesses, recurring or current? No: ___ Yes (elaborate next page): ___
Do you have any cardiac or cardiovascular conditions, recurring or current? No: ___ Yes (elaborate next page): ___
Are there any significant restrictions on your physical activity? No: ___ Yes (elaborate next page): ___
Do you have any other medical conditions relevant to the program? No: ___ Yes (elaborate next page): ___

MEDICAL PROVIDER (to be signed by the relevant medical provider if any critical questions were answered "yes"):

I, the undersigned, have discussed all relevant medical issues with the participant including those noted above and clear the participant to participate in Project W.I.L.D. Any qualifying statements, comments, or restrictions are noted below:

Signature: ____ Date: ____/____/_____
Name: ____ Work phone: (________) ________-__________
Comments (attach a separate sheet if necessary): ____

NAME: ______________________________

PROJECT W.I.L.D. MEDICAL HISTORY FORM

Please explain any "yes" answers from the questions above in the space provided on the back of this sheet. Include specific symptoms, frequency of occurrence, duration of symptoms, date of last occurrence, care for your symptoms, and any restrictions associated with your condition. Also include names of any medications to which you have had adverse reactions, any medications you are currently taking and/or will be taking during the trip, and any information you want provided to emergency personnel in case of a medical emergency (attach a separate sheet if necessary):

____

____

____

____

List any medications you are currently taking: (bring these on the trip)

____

____

____

Please explain and specify any "yes" answers you have from the dietary restrictions:

____

____

Emergency Contact:

Name:_______________________________________ Relation to participant: ______________________

Primary phone: (________) ________-__________ Secondary phone (if applicable): (________) ________-__________

PARTICIPANT ACKNOWLEDGEMENT (to be signed by the participant):

I, the undersigned, have discussed all relevant medical issues and critical "yes" answers above with my medical provider and have been cleared to participate in Project W.I.L.D. The information I have provided above is complete and accurate to the best of my knowledge. I understand that only a designated medical reviewer and the appropriate Project W.I.L.D. staff will view this information. I authorize the medical reviewer to discuss this information with my medical provider, parent/guardian or the Project W.I.L.D. staff as needed to determine my fitness for this activity.

Signature: ____ Date: ____/____/_____

LEGAL GUARDIAN ACKNOWLEDGEMENT (to be signed by legal guardian if participant is under 18):

I, the undersigned, as parent or guardian of the above designated Project W.I.L.D. program participant who is under the age of 18 years, have discussed all relevant medical issues and critical "yes" answers above with my child's medical provider and he/she has been cleared to participate in Project W.I.L.D. The information I have provided above is complete and accurate to the best of my knowledge. I understand that only a designated medical reviewer and the appropriate Project W.I.L.D. staff will view this information. I authorize the medical reviewer to discuss this information with his/her medical provider or the Project W.I.L.D. staff as needed to determine his/her fitness for this activity.

Signature: ____ Date: ____/____/_____

Name: ____ Primary phone: (________) ________-__________

MEDICAL REVIEWER SECTION (to be signed by Duke Student Health Reviewer):

Signature: ____ Date: ____/____/_____

Comments: ____

____