The TRAILBLAZERS Pledge

TRAILBLAZERS activities are challenging. They are also fun. Through them, you will grow strong, meet new friends and travel to new places. Since using alcohol, tobacco and other illegal drugs will cloud your thoughts, reduce your strength, and put you and those around you in unsafe situations, they have no place in our program. We ask all TRAILBLAZERS - trip leaders, participants and volunteers alike - to make the following pledge before participating in the TRAILBLAZERS program:

"I am a TRAILBLAZER.
I recognize that it is important
for my safety and for the safety of others that I am
in control of my thoughts and my actions.
Therefore I will keep my mind and my body free
of alcohol, tobacco and any other drug that is illegal
for me to use. I signify my willingness to make this
pledge by tracing my hand over these words
and by my signature below."

_____ _____
TRAILBLAZER Signature **Parent/Guardian Signature**

_____ _____
TRAILBLAZERS Leader Signature **Expiration Date**

TRAILBLAZERS is a program of the Drug and Alcohol Prevention Education Department of Hamilton County Community Services.

Packet Information

Participant Name _____ Age____

Parent(s)/Guardian(s) Name (get spelling, may be different)

_____

Mailing Address _____

_____

Telephone Day_____ Evening_____
Best time to call:_____

Physical Address (e.g., Hope residents use a Northville address. We need to Know the actual address for pick-up/drop-off purposes.)

_____

_____

Permission, Acknowledgement of Risk and Release of Claims

Hamilton County Community Services - TRAILBLAZERS

Name of Participant: (print clearly) _____

The safety and well being of all participants are the top priorities of TRAILBLAZERS. Reasonable care and precautions are taken to minimize risk and to ensure a quality educational experience. However, it is neither possible nor healthy to eliminate all risk from TRAILBLAZERS. The following acknowledgement and release is both a participation requirement and reminder to you of the importance of being properly prepared.

I or my child _____, desire to participate in the TRAILBLAZERS program. I understand that TRAILBLAZERS is offered through Hamilton County Community Services. Outings include, but are not limited to, the following potentially hazardous activities: backpacking, bouldering, camping, canoeing (flat and swift water), indoor sport climbing, initiative (teamwork) activities, hiking, mountain biking, bouldering, high/low ropes course events, mountain biking, orienteering, sailing, top rope rock climbing and transportation using county vehicles. Outings may also include spectator events in large, urban, public settings, such as professional sporting events and concerts. Participation in any of these activities is potentially hazardous and may result in property damage, personal injury, illness, trauma or death.

●▶ **INITIAL** PARENT/GUARDIAN_____ PARTICIPANT_____

I understand that TRAILBLAZERS is a voluntary program. I have freely chosen to participate and I hereby assume the risks associated with TRAILBLAZERS.

In recognition of the potentially hazardous nature of this voluntary program, I or my child, my heirs and assigns hereby release Hamilton County and its agents, officers and employees from all claims and liability from negligence arising from participation in the TRAILBLAZERS program. I further agree to hold harmless and indemnify Hamilton County and its agents for all defense costs, including attorney's fees, and any other costs resulting in connection with my child's participation in this activity.

I understand that this release relates to all claims and liability during or after the trip resulting from a preexisting medical condition. I have read and completed fully the medical form provided by TRAILBLAZERS and accept full responsibility for omissions or errors on the medical information form.

I also understand that this release relates to all claims and liability resulting from unforeseen or intemperate weather. I have read the clothing and equipment list provided by TRAILBLAZERS and accept full responsibility for inadequate clothing or equipment provided by me or which I fail to provide.

Prior to signing this document, I have had an adequate opportunity to read and understand it, have had an opportunity to ask questions about it, and any questions I have had have been answered to my satisfaction.

❷▶ **Participant Signature**: _____ Date: _____

❷▶ **Parent/ Legal Guardian Signature** _____ Date: _____

(Parent or legal guardian must sign if participant is under 18 years of age)

Parent/ Legal Guardian print name: _____

Health Insurance Information

Hamilton County Community Services - TRAILBLAZERS

Name of Participant: _____ (print clearly)
Name of Person completing this form: _____ (print clearly)

TRAILBLAZERS is a program offered through Hamilton County Community Services (HCCS). Participation in TRAILBLAZERS activities carries with it the risk of accident and injury. If an accident or injury occurs during supervised TRAILBLAZERS outings, or during transportation to or from a supervised TRAILBLAZERS outing, your family's health insurance will be the *primary coverage*. TRAILBLAZERS, through Hamilton County, provides student accident coverage. Student accident coverage serves as *secondary coverage* unless there is no health insurance. In this case, the student accident coverage will serve as the primary insurance coverage. If you would like information about the student accident coverage, please call us for details.

▶ **Your answers to these questions will be kept confidential.**

Is the participant covered by health insurance? Yes____ No____

If yes, please provide us with the following information:

1. Name of Insurance Provider: _____
2. Policy Number _____
3. Identification Number _____
4. Group Number (if different) _____
5. Primary Card Holder Information
   - Name: _____
   - Billing Address: _____
   - Telephone Number: _____

6. Any other information the treatment facility needs to know about your coverage?

_____

_____

7. Does your insurance/health provider require that you contact them before treatment?
   Yes ___ No___

If yes, please provide us with the following information

- Contact Name _____
- Telephone (___) -_____-_____
- Contact address _____

_____

▶ Please attach a copy of <u>both</u> <u>sides</u> of your health insurance card.

Form # 4: Medical History, Medical Release & Photo Release (page 1)

Hamilton County Community Services - TRAILBLAZERS.

This information helps us to better know participants and is kept confidential. This information will NOT be released to anyone, even in the event of an emergency, unless you also complete the optional Medical Release, found on the bottom of the reverse side of this form. We update this information annually. We recommend that parents and participants complete this form together.

▶ **Complete both sides of this form and please print.**

Participant's Name: _____ Telephone #: _____

Parent/ Guardian Name: _____

Mailing Address: _____

Birthdate: ___/___/___ Ht: ___ft. ___in. Weight: _____ Shoe Size: _____ T-Shirt Size: _____

Family Physician (or location of medical records): _____ telephone #: _____

Date of last visit ____/_____/____ reason: _____

Does your daughter/son wear any of the following: contact lenses? ___ glasses? ___ braces/retainr? ___
hearing aid? ___ knee brace? ___

Has your daughter started menstuating? Yes___ No___ If yes, approximate start date _____

Are there any physical or mental limitations that would prevent your son or daughter from fully participating in TRAILBLAZERS activities? Yes ____ No___

If yes, please explain: _____

▶ **MEDICATION** Is your son/ currently taking medications, including vitamins and/or herbal supplements? Yes___ No__

If yes please indicate what state what is being taken, why it is being taken and how often it is taken. _____

▶ **ALLERGIES**:

medicine(s)? (list) _____

food (s)? (list) _____

environmental, animals or insects?(list) _____

▶ **RECENT HISTORY**: In the last six (6) months, has your daughter or son had any of the following:

___change in appetite ___change in vision ___chronic cough ___bronchitis
___frequent headaches ___ear aches ___sinus infection ___pneumonia
___growth spurt ___knee pain ___fainting/blackouts ___mononucleosis
___upper respiratory infection ___urinary tract infection

Please explain and give dates for any items checked:

_____

_____

_____

▶ **DATE OF LAST TETANUS BOOSTER:** _____

Form # 4: Medical History, Medical Release & Photo Release (page 2)

Hamilton County Community Services - TRAILBLAZERS,

▶ **HISTORY** Does your daughter/son have, or have they had, any of the following? Check all that apply

___anemia	___anorexia	___back problems	___broken bones
___bulimia	___cancer	___diabetes	___heart murmur
___hemophilia	___hernia	___high blood pressure	___hypoglycemia
___irregular heart beat	___injured joints	___low blood pressure	___migraines
___scoliosis	___surgery	___tuberculosis	___tumor

___OTHER (explain)

Please explain and provide details to any items checked above:_____

_____

_____

Does your son / daughter smoke or chew tobacco? Yes___ No___ Unsure___

Is there anything else that you would want a physician to know about your son or daughter in the event of an emergency? _____

_____

I have filled in the above and believe it to be true to the best of my knowledge:

Participant Signature: _____ Date: _____

Parent/ Guardian Signature: _____ Date: _____

Medical Release (optional)

PURPOSE: This *optional* release will enable us to obtain appropriate medical attention or treatment in the event of an emergency. We will always try to reach you as soon as possible using the information you provide. However, since TRAILBLAZERS outings often take place in remote settings, we may not be able to reach you. If you choose not to sign this release, medical attention/ treatment may be withheld until you are contacted by the treatment facility and give verbal consent. **Fill out the information below if you wish to provide us with a Medical Release.**

Emergency Care Authorization for _____ (participant's name)

"In the event that I cannot be reached by telephone, I hereby give my permission to TRAILBLAZERS staff to seek appropriate medical attention. By my signature below, I authorize any licensed physician, or medical professional under the supervision of a licensed Physician, to secure appropriate treatment and or perform any procedure which in his/her opinion is necessary in light of the condition of the above named participant"

Parent/ Guardian Signature: _____ Date: _____

Tel. # to reach me in an emergency( )_____ Alternate tel. # ( )_____

If I am unavailable, please contact _____ @ ( )_____

Relationship of the above named person to you: _____

Photo Release

I understand that any photographs taken during a TRAILBLAZERS activity can be used at the discretion to TRAILBLAZERS staff and for promotional purposes.

Participant Signature: _____ Date: _____

Parent/ Guardian Signature: _____ Date: _____