



2523 14 ³/₄ Avenue
Rice Lake, WI 54868
715.859.6670 phone
715.859.6669 fax
naturesedge@citizens-tel.net
www.naturesedgetherapycenter.org

YOUTH OF PROMISE REGISTRATION PACKET

PARTICIPANT APPLICATION AND HEALTH HISTORY

To be completed by the participant, or parent/legal guardian

GENERAL INFORMATION

Participant Last Name: _____ First Name: _____
Date of Birth: _____ Age: _____ Height: _____ Weight: _____ M F
Address: _____
City: _____ St: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Alternative Phone: _____
Employer/School: _____
Address: _____
Supervisor/Teacher: _____ Phone: _____
Parent/Legal Guardian(s): _____
Address (if different from above): _____

How did you hear about the program? _____

HEALTH HISTORY

Please indicate current or past problems in the following areas:

| | <u>Yes</u> | <u>No</u> | <u>Comments</u> |
|--------------------|------------|-----------|-----------------|
| Vision | ___ | ___ | _____ |
| Hearing | ___ | ___ | _____ |
| Sensation | ___ | ___ | _____ |
| Communication | ___ | ___ | _____ |
| Heart | ___ | ___ | _____ |
| Breathing | ___ | ___ | _____ |
| Digestion | ___ | ___ | _____ |
| Elimination | ___ | ___ | _____ |
| Circulation | ___ | ___ | _____ |
| Emotional | ___ | ___ | _____ |
| Behavioral | ___ | ___ | _____ |
| Pain | ___ | ___ | _____ |
| Bone/Joint | ___ | ___ | _____ |
| Muscular | ___ | ___ | _____ |
| Thinking/Cognition | ___ | ___ | _____ |
| Allergies | ___ | ___ | _____ |

What medications are you currently taking, including over the counter medications? _____

Describe your abilities/difficulties in the following areas, include assistance required or equipment needed:

FUNCTION (i.e., mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

SOCIAL (i.e., work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)

GOALS (i.e., Why are you applying for participation? What would you like to accomplish?)

RELEASE FORMS

PHOTO RELEASE

I consent to and authorize the use and reproduction by Nature’s Edge Therapy Center, Inc. of any and all photographs and any other audio-visual materials taken of the camp attendee, camp attendee family, patient, patient family or friends during sessions, for promotional material, educational activities, exhibition, or for any other use for the benefit of the program.

Signature of Parent or Legal Guardian

Date

DAMAGE RELEASE

I, _____ (Parent/Guardian’s Name) understand that if my child or heirs causes harm to Nature’s Edge Therapy Center or property of Nature’s Edge Therapy Center or the Lundeen farm used by Nature’s Edge Therapy Center, I will be responsible for the damage.

Signature of Parent of Legal Guardian

Date

REGISTRATION AND RELEASE FORM

I, _____ (Parent/Guardian’s Name) would like my child to participate in Nature’s Edge Therapy Center, Inc.’s Youth of Promise program. I acknowledge the risks and the potential for risks of the programs use of horses and other animals. However, I feel that the possible benefits are greater than the risks assumed. I hereby forever release, discharge, and hold free and harmless, for myself, my heirs, and assigns, executors or administrators, all claims for damages against Nature’s Edge Therapy Center, Inc., it’s instructors, therapists, aides, volunteers and /or employees, and the Lundeen Ranch of any and all injuries and/or losses the client or clients family may sustain while participating in the Youth of Promise program. A \$300 fee is required to secure enrollment in the “Youth of Promise” program.

Signature of Parent or Legal Guardian

Date

Signature of Participant

Date

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Primary Physician's Name: _____
Clinic Name: _____
Address: _____
City: _____ St: _____ Zip: _____
Phone: _____ Ext: _____

In the event of an emergency, contact:
Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____

In the event of an emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of Nature's Edge Therapy Center, Inc., and the above cannot be reached, I authorize Nature's Edge Therapy Center, Inc., to:

- Secure and retain medical treatment and transportation if needed.
- Release participant records upon request to the authorized individual or agency involved in the medical emergency treatment.

Consent Plan

This authorization includes X-ray, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person above is unable to be reached.

Consent Signature: _____ Date: _____
Parent or Legal Guardian

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving or while being the property of Nature's Edge Therapy Center, Inc. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Non-Consent Signature: _____ Date: _____
Parent or Legal Guardian

A COPY OF THE COMPLETED MEDICAL HISTORY SHOULD BE ATTACHED TO THIS FORM

MEDICATION POLICY

Please read the following carefully.

The medication policy must be filled out and signed by the first day of the “Youth of Promise” program. Even if no medications are taken during the time the attendee is at the camp, this form must be signed and turned in. If there are any changes in medication, the Youth Directors must be notified.

Effective as of July 11, 2008, any medication (nonprescription and/or prescription) taken by Youth of Promise attendees must be turned in by parents/guardians to the Youth of Promise directors each morning. Medications will be locked in a cabinet and administered by the directors at the necessary times.

Please list any medications (nonprescription and/or prescription) that will be taken by your youth during Youth of Promise program and times at which they need to be taken below. Please sign and date this document showing you have read and agree with this medication policy. Thank you for your cooperation!

| <u>Medication</u> | <u>Time to be Taken</u> |
|--------------------------|--------------------------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

I acknowledge that I have read the policy and agree to the terms presented above:

Signature of Parent or Legal Guardian

Date

PARTICIPANT INTEREST SURVEY

Name: _____

Age: _____ Date: _____ Grade Level: _____

School you attend: _____

What are your hobbies? _____

What do you hope to accomplish during Youth of Promise program?

What activities are you most interested in participating in? _____

What is your favorite animal? _____

What, if any, previous experiences have you had working with large and/or small animals?

What, if any, previous experiences have you had with gardening and/or landscaping projects?
