Student Name: _____

7th Grade Outdoor Education Trip
El Capitan Canyon
March 24-27, 2015

Dear Parents and Guardians:

Attached you will find a packet of information and forms to be completed, signed and returned in order for your child to attend our El Capitan Outdoor Education Trip.

The asking donation for the trip is $500. Please make your donation check payable to El Rodeo Class of 2016 and put your child's **FULL NAME** on the check. If there are financial concerns, please email Kevin Allen ASAP.

PLEASE RETURN THIS SHEET WITH THE FOLLOWING FORMS AND DONATION CHECK TO MRS. GOLDSOBEL NO LATER THAN MONDAY, MARCH 2, 2015.

Please check off the items you are returning:

_____ Participant Agreement (is it signed?)

_____ Medical Form (both sides - make sure to answer all questions and list special needs)

_____ Behavior Contract (has your child signed?)

_____ El Rodeo Field Trip Permission Form

_____ Allergy and Dietary Needs Form

_____ Donation check payable to El Rodeo Class of 2016 for $500.00

If there are any questions, please contact April Goldsobel at El Rodeo by email at agoldsobel@bhusd.org .

W.O.L.F.

Participant Agreement, Release, and Acknowledgement of Risk

In consideration of the Wilderness Outdoor Leadership Foundation, Inc. d.b.a. W.O.L.F., their agents, owners, officers, volunteers, participants, employees, and all other persons or entities acting in any capacity on their behalf (herein after collectively referred to as "W.O.L.F"), I hereby agree to release and discharge W.O.L.F., on behalf of myself, my children, my parents, my heirs, assigns, personal representatives and estate, as follows:

1. I acknowledge that my participation in outdoor adventure-based activities such as, but not limited to rock climbing, ropes or challenge course, trust falls, team initiatives, hiking, camping, sea kayaking, and swimming entails known and unanticipated risks which could result in physical or emotional injury, paralysis, death or damage to myself, to property, or to third parties, but that such risks simply cannot be eliminated without jeopardizing the essential qualities of the activity.

2. I expressly agree and promise to accept and assume all reasonable risks existing in this activity. My participation in this activity is purely voluntary, and I elect to participate in spite of the risks.

3. I hereby voluntarily release, forever discharge, and agree to indemnify and hold harmless W.O.L.F. from any and all claims, demands or causes of action, which are in any way connected with my participation in this activity or my use of W.O.L.F.'s equipment or facilities, including any such claims which allege negligent acts or omissions of W.O.L.F, but excluding gross negligence, intentional malfeasance or nonfeasance, or acts of malice.

4. Should W.O.L.F. or anyone acting on their behalf, be required to incur attorney's fees and costs to enforce this agreement, I agree to indemnify and hold them harmless for all such fees and costs if an action is commenced and W.O.L.F. is determined by the court to be the prevailing party.

5. I certify that I have adequate insurance to cover any injury or damage I may suffer while participating, or else I agree to bear the costs of such injury or damage to myself. I further certify that I know of no medical or physical conditions that would interfere with my safety in this activity, or else I am willing to assume and bear the costs of all risks that may be created, directly or indirectly, by any such conditions.

6. The parties agree to submit to binding arbitration any dispute regarding the terms or interpretation of this agreement.

7. The laws of the state of California will govern the resolution of any conflict regarding this agreement.

I have had sufficient opportunity to read this entire document. I have read and understood it, and I agree to be bound by its terms. I understand that photos and video taken during the program may be used for promotion and advertising.

Signature of participant:_____ Print name:_____
Address:_____ Phone:_____
City:_____ State:_____ Zip:_____
School/Organization:_____ Date:_____

Parent's or Guardian's Additional Indemnification
(Must be completed for participants under the age of 18)

In consideration of _____(print minor's name) ("Minor") being permitted by W.O.L.F. to participate in these activities and to use its equipment and facilities. I further agree to the terms of paragraph 3 above with respect to any and all claims which are brought by, or on behalf of, Minor.

Parent or Guardian:_____ Print Name:_____ Date:_____

W.O.L.F.

Medical Information Form

Please Complete both sides of form

General Information

Name_____
Address_____
City_____State_____Zip_____
Home Phone_____Business_____Cellular_____
Other phone #1_____Other phone #2_____Other phone #3_____
Male( ) Female( ) Height_____Weight_____Birth Date_____

Medical Information

Family Physician_____Phone_____
Address_____
Person to be notified in case of emergency_____
H. Phone_____ B. Phone_____ Relationship_____
Date of last Tetanus booster_____
List medications to which you are allergic_____
_____
List all other allergies_____
_____
_____

Have you ever been stung by a bee or a wasp?_____When?_____More than once?_____
Are you allergic to bee stings?_____ If yes, do you carry medications? _____
Name of medication_____Nature of reaction_____

Medical History

List illnesses or conditions that you are now undergoing treatment and list all medications you are currently taking_____
_____
If you have any of the following, state the year of occurrence and the location on your body:
Hernia_____Fracture_____
Dislocation_____ Sprain or Strain_____
Name any injuries, illnesses, or disability not mentioned and year of occurrence:
_____
_____
_____

If you have been hospitalized, list below:
Date_____Name and location of hospital_____
Illness or Injury_____
Date_____Name and location of hospital_____
Illness or Injury_____
Date_____Name and location of hospital_____
Illness or Injury_____

Medical History Continued

If you now have, or have had any of the following symptoms or conditions, please circle "YES", underline and describe the problem. If not, circle "NO".

a) YES NO Dizziness, Loss of Consciousness, or Recurrent Headaches
b) YES NO Eye, Ear, Nose, Throat, Tonsils, or Sinus Symptoms
c) YES NO Impairments of sight, Hearing, or Speech
d) YES NO Chronic Cough, Bronchitis or Asthma, Coughing up of Blood, Close Contact with Tuberculosis
e) YES NO Chest Pain, Shortness of Breath, Palpitation, Swelling of Ankles, Heart Murmur, Heart Disease, High and Low Blood Pressure
f) YES NO Reaction to Bee Stings
g) YES NO Sensitivities/Allergies to: Horse Serum (Tetanus Antitoxin), Sulfa, Penicillin, or any other drug
h) YES NO Symptoms relating to the Gastro Intestinal Tract (ie: Diarrhea, recurring abdominal pain, passing of blood, ulcer of stomach or duodenum)
i) YES NO Severe Menstrual Cramps or Menstrual problems, Currently Pregnant
j) YES NO Albumin, Sugar or blood in urine; Kidney Stone, Frequency in Urinating, Bed Wetting, or other Urinary Difficulties
k) YES NO Muscle, Joint, Knee or Back Pain, Bursitis, Arthritis, Sciatica
l) YES NO Benign or Malignant Growth or Tumor
m) YES NO History of Diabetes, Thyroid Imbalance, Hypoglycemia
n) YES NO Episodes of Depression, Anxiety, Hysteria, Nervousness
o) YES NO Special Dietary Restrictions, ie: Diabetic, Low Cholesterol, Vegetarian, etc.

Give details to all of the questions above to which you circled "YES"

_____
_____
_____
_____
_____
_____
_____
_____

Insurance

We do not provide sickness or accident insurance for participants. Therefore, it is each participant's responsibility to be covered by his or her own hospitalization policy.

Does any hospitalization or medical care policy cover you? _____

If yes, indicate name of insurance company issuing policy _____

_____

Policy or Certificate Number _____

Signature (If participant is under 18 years of age, parent or guardian MUST sign)

In the event of an accident or emergency, I grant permission for any medical care, operations, and/or anesthesia that might become necessary as deemed by emergency medical personnel and WOLF staff and directors.

Signature _____ Date _____

Print Name _____ Relationship _____

WOLF Behavior contract

Due to the adventure component of *WOLF* environmental education courses, we request that students agree to the following guidelines so that the safety of everyone can be insured. Safety violations may result in the immediate removal from the course.

I agree to participate in the *WOLF* learning adventure by:

a. Trying new activities and learning techniques.
b. Being on time to activity sessions.
c. Working to help others who might have difficulty with some activities.

I agree to be courteous and polite by:

a. Being a good team member, sharing, and taking turns.
b. Listening and following directions.
c. Doing my share of work.
d. Respecting other people's belongings.
e. Not fighting or using bad language

I agree to follow the rules of *WOLF* by:

a. Staying with my group.
b. Walking and not running in camp.
c. Leaving rocks, sticks and other things on the ground and not throwing them.
d. Respecting the plants, insects, reptiles and other animals by observing them and leaving them alone.

I agree to leave these things at home:

a. Candy, gum, food - these things will attract skunks and ants.
b. Money.
c. Radios and electronic games.
d. Blow dryers and curling irons.
e. Aerosol spray cans.
f. Knives - unless approved by the school administration.

I understand that if I choose to violate this agreement the following steps may be taken:

a. Behavior improvement request by *WOLF* staff - 1st warning.
b. Discussion with the school staff - 2nd warning.
c. Phone call to the parent - final warning.
d. Parents will be called to take me home.

Depending on the severity of the violation, I understand that I may be sent home without previous warnings. I have read this contract and agree to follow these rules as they are outlined. I understand that I may lose my privilege to attend if I violate them.

Student Signature: _____ Date _____

Print Name: _____

Parent/guardian Signature: _____

BEVERLY HILLS UNIFIED SCHOOL DISTRICT
STUDENT PARTICIPATION IN DISTRICT-SPONSORED VOLUNTARY FIELD TRIP
PARENTAL PERMISSION, ASSUMPTION OF RISK, AND
MEDICAL TREATMENT AUTHORIZATION

Date 1/28/15

Student's Name: _____ has permission to participate in the following field trip:

Destination/Nature of Activity El Capitan Canyon / 7th Outdoor Ed. Class Trip
(Please be specific, e.g., Concert at UCLA.)

Special Instructions: _____
(e.g., Bring sack lunch.)

Departure Date: 3/24/15 Time: 7:00 AM Date: 3/27/15 Return Time: 3:00 PM

Itinerary Attached; please read carefully and note all travel arrangements.

Person in Charge: April Goldsobel Position: Teacher School: El Roded

Type of Transportation: **Various modes of transportation may be used, some of which involve a risk that cannot be ascertained by the BHUSchool District.**

Health or special needs: Check as appropriate.

	My student has no special health needs the staff should be aware of, and no medication is required on the trip.
	My student has a special need, and instructions are attached. Number of attached pages:_____.
	Other:

In the event of illness or injury, I do hereby consent to whatever x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care and emergency transportation considered necessary in the best judgment of the attending physician, surgeon, or dentist and performed under the supervision of a member of the medical staff of the hospital or facility furnishing medical or dental services.

I fully understand that participants are to abide by all rules and regulations governing conduct during the trip.

As provided for in California Education Code Section 35330, I agree to waive all claims against the Beverly Hills Unified School District (District) and hold the District, its officers, agents and employees, harmless from any and all liability or claims, which may arise out of or in connection with my child's participation in this activity. This waiver shall not apply to any occurrences which may arise solely out of the negligence of the District, its employees or agents.

_____ _____ Work Phone ( )_____
Signature (Parent/Guardian) (Please Print Name)
Home Phone ( ) _____

_____ _____
Student's Date of Birth Student's Signature

Family Medical
InsuranceCarrier: _____ Policy Number: _____
(e.g., Blue Cross)

In the event of an emergency, please contact:

_____ _____ Work ( ) _____
(Name) (Relationship)
Home ( ) _____

Allergy and Dietary needs:

Student Name: _____

No Known Allergies/Medications _____

(please check if this applies)

Medication Allergies:

_____

_____

Food/Environmental Allergies:

_____

_____

Prescription Medications and Dosage for trip

_____

_____

Special Dietary needs: (for example Kosher)

_____

_____