

WILDERNESS LEADERSHIP & LEARNING APPLICATION

The undersigned certify that the information provided in this Application is true and accurate and may be relied upon by Wilderness Leadership & Learning, Inc. ("WILL") for all purposes and that the Acknowledgement of Personal Responsibility, Assumption of Risk and Release, a copy of which is attached to this Application and made a part of this Application, is binding upon the Applicant and the Applicant's parent(s) or legal guardian.

PART I Personal Information

Applicant Name: _____
First Middle Last Preferred.

Home Address

Street (include apt., box, etc.) _____

Phone Number: _____

E-mail Address: _____

City State Zip _____

Cell Phone: _____

DC WARD: ____ Birth Date: ____/____/____ Age: ____ Sex: (Check one) F M Height ____ Weight ____
Mo. Date Year

Education

Current School Attending: _____ Do you speak/understand English: Yes No

Grade Level: _____ My School has Free and Reduced Meals (FARMS): Yes No

Please indicate ethnic origin. Responding is optional. (Please check the one that best describes you):

Native American Hispanic African-American Caucasian Asian Pacific Islander Other _____

Parent or Legal Guardian Information (person with whom Applicant lives)

(Mr., Mrs., Ms., Dr.) _____

Address is the same as the student's permanent address.

If not: _____
Street

City State Zip _____

Phone: Day _____ Evening: _____

E-mail Address: _____

A Few Questions (just to help us learn something about you)

What is your favorite thing to do? Least favorite? _____

Why do you want to participate in WILL? _____

If you could meet any three (3) people (dead or alive) who would you choose and why? _____

PART II Medical Information

FAMILY PHYSICIAN	
Name _____	Telephone # (____) _____ FAX # (____) _____
INSURANCE INFORMATION	
Each participant is responsible for any medical expenses and should be covered by his/her own illness and accident insurance. Please answer the following questions for our insurance records: <i>(Please attach a photocopy of both the front and back of your insurance card)</i>	
DO YOU HAVE INSURANCE? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Insurance Company _____	Policy/Certificate # _____
Prescription Plan # _____	Telephone # (____) _____

A. Allergies (Including allergies to medicines, foods, insect bites/stings) NONE or...

Allergy	Reaction	Medication Required (if any)

B. Current Medications (Including psychiatric medication, over-the-counter medication, inhalers) NONE or...

Medication	Taken For: (Symptom/Condition)	Dosage	Date Started	Current Side Effects

Wilderness Leadership & Learning, Inc. recommends that all of its participants have a current tetanus immunization (within 10 years).

PART III Health Profile

#	Please <input checked="" type="checkbox"/> yes or no -- <u>If yes, describe below</u>	Y	N	#	Please <input checked="" type="checkbox"/> yes or no -- If yes, describe below	Y	N
1	Seizure within the past 1 year			7	Use of tobacco/Smoker		
2	Hospitalization/Emergency Room/Urgent Care visit within the past 1 year			8	Current Neck/Back/Shoulder/Knee/Ankle/or other joint problem		
3	Asthma (If yes, please bring inhaler)			9	Currently Pregnant		
4	Unexplained chest pain/pressure, shortness of breath, rapid heartbeat, sweats, or exertional dizziness or faint spells Unexplained chest pain/pressure, shortness of breath, rapid heartbeat, sweats, or exertional dizziness or faint spells which occur often			10	Bedwetting		
				11	Diagnosed Learning Disability and/or ADD/ADHD		
5	Other cardiac conditions, e.g., heart murmur or other rhythm abnormality			12	Other medical issues/illnesses/symptoms/ requirements/prosthetic device(s), including without limitation, Tuberculosis(TB), recent exposure to TB or positive TB test, seizure within past 1 year, epilepsy, bleeding disorder, diabetes, hypoglycemia, hepatitis.		
6	High blood pressure						
#	Describe						
#	Describe						
#	Describe						

PART IV Counseling History

Please <input checked="" type="checkbox"/> yes or no to the following questions:		Yes	No
1	Have you been in counseling with a psychiatrist, psychologist, social worker, or other therapist within the past 2 years?	<input type="checkbox"/>	<input type="checkbox"/>
2	Are you currently in counseling or treatment with a therapist, psychiatrist, psychologist, or prescribing physician?	<input type="checkbox"/>	<input type="checkbox"/>
3	Please arrange for a release of information with your therapist and/or prescribing physician so we may contact them for further information as part of this screening process. Have you done so?	<input type="checkbox"/>	<input type="checkbox"/>
4	Please check the appropriate responses that indicate the reason(s) for counseling: <input type="checkbox"/> Academic/Career <input type="checkbox"/> Divorce <input type="checkbox"/> Family Issues <input type="checkbox"/> Maintenance of Medication <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Depression <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Suicide <input type="checkbox"/> Other _____		
5	Name of current (or most recent) therapist _____ Telephone # (_____) _____ FAX # (_____) _____ email _____		
6	Name of prescribing physician _____ Telephone # (_____) _____ FAX # (_____) _____ email _____		

PART V Cardiovascular Fitness

A. Current Exercise Activity

Please list the activities you do on a daily or weekly basis which show your current fitness level. Be sure to include activities such as walking a pet, mowing a lawn--or after school activities such as playing basketball, skateboarding, skiing, etc.

Activity	Frequency	Approximate Time/Distance	Leisurely	Moderately	Intensely

PART VI Person to Notify in Case of an Emergency

All applicants must identify below a Primary (parent/guardian - generally person listed on 1st page of Application) and secondary person (a person other than parent/guardian identified in #1) to contact in case of an emergency:

1. Primary: Name _____ Phone: Day _____ Evening _____

Address _____
 Street _____ City _____ State _____ Zip _____

Relationship to applicant: (Please check one): parent guardian

2. Secondary: Name _____ Phone: Day _____ Evening _____

Address _____
 Street _____ City _____ State _____ Zip _____

Relationship to applicant: (Please check one): parent other relative (specify _____) friend guardian

—APPLICATION CONTINUES ON NEXT PAGE—

We (parent/guardian Applicant) and have read, understand, accept and agree to abide by the rules, policies and guidelines established by WILL. I (parent/guardian) understand that the relationship between me (my child/ward) and WILL, including without limitation the Acknowledgement of Personal Responsibility, Assumption of Risk and Release, will be governed by the substantive laws of the District of Columbia and any suit, mediation or arbitration of any dispute with WILL must be filed exclusively in the District of Columbia.

I understand that I am (my child/ward is) not accepted into a WILL program until all enrollment forms have been received and approved by WILL and all conditions for acceptance to a WILL program have been fulfilled.

I agree to provide my (my child's/ward's) report cards, attendance records and immunization forms to WILL and/or authorize DC Public Schools or the DC Public Charter School which I attend (my child/ward attends) to provide Steve Abraham of WILL (or other duly authorized representative of WILL) a copy of my (my child's or award's) report cards, attendance records, and immunization forms.

I give WILL permission to use my (my child's/ward's) name, contact information, picture, likeness, voice, and quotes in promotional, recruiting, and fundraising materials, websites, and press releases, and any other materials for the benefit of WILL in whatever medium presented, whether now known or hereafter devised.

Consent is hereby given for the applicant to attend WILL programs and permission is given for any emergency anesthesia, operation, hospitalization or other treatment that may become necessary.

All information provided in this Application will remain confidential, except as necessary to provide medical care. WILL must be aware and advised of all medical/psychological conditions. Failure to disclose such information could result in serious harm to your child or ward and fellow WILL participants.

We have read and agree to the following WILL Attendance Policy: I _____ (insert name of Applicant) commit to attend all WILL activities. WILL and we understand that conflicts sometimes come up and one cannot always do what one commits to do. **I will dismiss myself from WILL if I (WILL Participant) miss:**

**3 WILL Activities without communicating with WILL to inform WILL that I cannot attend an activity;
A total of 4 WILL Activities;
The 7-Day Backpacking Expedition; or
WILL Graduation.**

In addition, we understand and agree that, upon completion of a WILL activity, all WILL youth will be returned to the place designated by WILL (usually, the initial meeting/parent drop-off point for the activity), unless WILL receives prior written notice of other arrangements from the WILL Youth's parent or guardian.

Signature of Applicant _____ Date ____/____/____

Signature of Parent or Guardian is also required, to reflect agreement, if applicant is under 18 years of age:

_____ Date ____/____/____

Please forward the completed Application to:
Wilderness Leadership & Learning, Inc.
Attn: Stephen H. Abraham
1758 Park Road, N.W.
Washington, D.C. 20010
(tel) 202-319-2765; (fax) 202-483-1206