

Release & Waivers: REQUIRED SIGNATURES

RELEASE, INDEMNIFICATION AND WAIVER FORM: (This is a release-please read it carefully)
I, the undersigned, hereby acknowledge that I have been advised and fully understand that certain elements of danger are inherent in the activities that may be engaged with during the Art of Mentoring which are beyond the control of the instructors, agents, officers, students, and employees of the event, and that participation in any program activities may entail unavoidable risk of personal injury, death, and loss or damage to property. The risks include, but are not limited to insect and animal bites and stings, forces of nature such as but not limited to lightning, and unexpected extreme weather conditions, and any hazard present in natural spaces, such as but not limited to low lying branches, sharp objects, and slippery surfaces.

I hereby assume all risks of injury and death to myself and loss of or damage to property arising out of my participation in such activity and I agree to indemnify, hold harmless the organisers of the Art of Mentoring, its officers, instructors, agents, and employees from and against all claims arising from any occurrence causing damage or injury to myself or to any party participating in the said event or any third parties injured as a result of my actions. I further agree to repair or reimburse the organisers of this event for any and all damages that I cause to the Green and Away property where this course is held.

I have read and understand the terms and conditions of this Release, Indemnification and Waiver and I agree to subscribe to them.

Participants' Signature:

_____ DATED: _____

Printed Name: _____

MEDICAL RELEASE:

The information provided on my Confidential Medical record and Participant Questionnaire is a complete and accurate statement of the physical and psychological factors which may affect my participation on the Art of Mentoring program. I realize that failure to disclose such information could result in serious harm to myself and/or fellow students. I agree to indemnify and hold the organisers of this event harmless if all relevant information is not disclosed. I also agree to notify the organisers of this event should there be any change in my health status prior to the start of my program or during the program.

Print Name _____

Signature _____ Date _____

I, _____ (print name), hereby give consent for emergency hospitalization if it becomes necessary as a result of participation in the Art of Mentoring program.

Signature _____ Date _____

PHOTO RELEASE: By signing below I hereby grant free permission for the organisers of the Art of Mentoring and the core instructors to use images of myself participating in their programs or events for outreach purposes, including but not limited to electronic or printed materials or media.

Please consider granting this release to us if at all possible, as our ability to successfully share our program with new participants depends on having representative photographs.

Signature: _____ Date: _____

NO, I do not wish to grant a photo release.

Signature: _____ Date: _____

Adult Confidential Medical Record

PART 1 General Information

Date _____ Program _____

Name _____ Age _____

Male Female Date of Birth _____ Height _____ Weight _____

Address _____

City _____ Post code _____

Phone (H) _____ (W) _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship _____

Home Phone (____) _____

Work/Other Phone (____) _____

Optional Alternate contact: _____ Relationship _____

Home Phone (____) _____

Work/Other Phone (____) _____

Optional Personal/Family Doctor _____

Phone (____) _____

PART 2 Medical Information

If you have any personal medical conditions or problems that the course organisers should be aware of, it is your responsibility to acquaint us with the existing condition both in this form as well as at the registration for the program. The information will be held in confidence and used only to render proper assistance should the need arise. You should know that it is possible for participants with a variety of medical/ psychological difficulties to successfully complete this course, but we must be aware of these conditions for our benefit. Failure to disclose such information could result in serious harm to you and your fellow students.

1. Do you wear: Glasses or contact lenses? _____
Hearing aid? _____

2. Do you have asthma? _____ If so, do you have medication?(specify) _____

3. Do you have a heart condition? _____ If so, please describe your limitation, medications (if any) and history:

4. Do you have any physical disabilities or limitations that could become a problem on this program? If so, please describe disability, limitation, and history:

5. Allergies/Intolerance to any insects, plants, foods, medications, etc. - List below. Please describe your reaction (if you know them) to any of the above.

6. List any medications that you take, condition prescribed for, and the doses and schedules for any such medications, and any known drug interactions. Do you experience any side effects?

7. Describe your current physical exercise activity. Include frequency, duration and intensity.

8. Answer "yes" or "no" below, for you

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | a. Seizure within past year |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | b. Family history of heart attack |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | c. Hospitalization within past 2 years |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | d. Emergency Department visit within past year |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | e. Neck, back, shoulder, knee, ankle pain or injury |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | f. Medical equipment needed |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | g. Been stung by a bee, or wasp |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | h. Smoke, drink alcohol, illicit drug user, or other addictive habits. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | i. Other medical issues, illnesses or symptoms |

Give details on any question for which you checked "yes". Include symptoms and/or any restrictions.

9. If you tick "yes" to any of the following questions, we strongly suggest that you consult

with a health care professional to determine whether your health status is sufficient for you to participate in the program:

- | | |
|------------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No a. High blood pressure (or currently being treated) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No b. Heart murmur |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No c. Heart issues (Current or prior heart disease, irregular heart beat, history of heart attack) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No d. Chronic, on-going disease such as diabetes, seizure disorder, bleeding disorder |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No e. Chest pain/pressure, heart palpitations, frequent unexplained or heart-related dizziness or fainting, sweats or weak spells. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No f. Age 45 or more with family history of heart attack and/or severely over weight |

Describe in detail any of the above for which you checked "yes" (include additional sheets if necessary):

10. Any mental, emotional or psychological issues we should be aware of at this time ? All information is kept confidential and is meant to provide a supportive and safe atmosphere for all involved in the program.

11. Do you have any dietary restrictions? If so, what are they?