

**Wolf Ridge Program Health Form & Release**  
**Return to: Wolf Ridge ELC - 6282 Cranberry Rd, Finland, MN 55603.**

Program Title: **Family Vacation**

Program Date: **July 21 - 26, 2008**

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Family E-Mail Address (if you have one) \_\_\_\_\_

Vegetarian meal option all week: \_\_\_\_ # in family

If there are other families attending this program you would like to have a room near you, please list.

Are you celebrating an important event during this program? Is so, what is it and on what date does it occur?

May we include your name, address, and e-mail (if you listed one) on a participant list to be distributed to all the participants of your program? \_\_\_NO \_\_\_YES

May we add your name to a list to receive future mailings on Wolf Ridge Family Programs?  
(You may receive 1-4 mailings per year) \_\_\_NO \_\_\_YES

If you listed an e-mail address, may we send you e-mail alerting you to future Wolf Ridge Family Programs?  
(You may receive 1-4 e-mailings per year) \_\_\_NO \_\_\_YES

Emergency Contact Person: \_\_\_\_\_ Relationship \_\_\_\_\_

Day phone: \_\_\_\_\_ Evening phone: \_\_\_\_\_

**Please complete both sides and mail to  
Wolf Ridge by July 4, 2008.**

**INSURANCE INFORMATION**

Physician or health care provider \_\_\_\_\_ Phone \_\_\_\_\_

Health insurance type (circle one):

Private/Group    Medicare    Medical Assistance    HMO    Other    None

Name of company \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_

I understand that I am financially responsible for all medical charges incurred on behalf of my dependents or myself. I authorize the health care provider to release all information needed to secure payment of benefits, and I authorize the use of this signature on all insurance claims for myself and/or my dependents.

Signature of participant or guardian \_\_\_\_\_

**Medical Information:** Please list below any health conditions or special circumstances we should know about for any of the family/party members you listed above. Please describe any allergies, the allergic reaction and how it is treated.

Do you have any food allergies or intolerances that the food service should be aware of? If so, please specify and read the section in the Program Details on Food Service.

**Assumption of Risk Agreement and Liability Release**

As a representative for my family/party, I am aware that this program involves certain risks, which I accept for all family/party members listed on the previous page. These risks may include, but are not limited to, being transported by van to certain activities, walking on rugged trails in various weather conditions, canoeing, rock climbing and belaying indoors, and participating on a high ropes course. In the event of an emergency and the absence of an adult in our party, I authorize treatment by emergency medical personnel. I understand that I am financially responsible for all medical charges incurred on behalf of myself or my dependents. I authorize the health care provider to release all information needed to secure payment of benefits, and I authorize the use of this signature on all insurance claims for myself and/or my dependent. I hereby release Wolf Ridge, all of their personnel, agents, affiliates, staff and directors, from all liabilities to me with respect to injury, sickness, disease, loss or damage. This release does not apply to liabilities arising from gross negligence or wanton or reckless conduct by anyone, including Wolf Ridge or their representatives. Apart from that exception, it applies to all liabilities, to me or my estate of any description, whether arising from ordinary negligence or otherwise, and whether involving fees and expenses of any kind.

In the event that some other entity seeks compensation for these released liabilities, I or my estate will indemnify and hold harmless Wolf Ridge for all sums reasonably incurred in response to that claim. This release is to be interpreted and enforced under Minnesota law.

I authorize Wolf Ridge to use any photos taken during the program and comments made on evaluations by participants in publicity materials for Wolf Ridge.

Family Representative Signature \_\_\_\_\_ Date \_\_\_\_\_