KAYAK PROGRAM WITH WASHINGTON COLLEGE
Sultana Projects, Inc. • 105 S. Cross Street • P.O. Box 524 • Chestertown, MD 21620 • PH 410-778-5954 • FAX 410-778-4531

MEDICAL AND GENERAL RELEASE FORM

NAME OF PARTICIPANT:_____
DATE/S OF TRIP: _____

Name of parent or guardian: _____
Address: _____
City: _____ State: _____ Zip: _____
Home phone: _____ Cell phone: _____
Father's employer: _____ Phone: _____
Mother's employer: _____ Phone: _____
Emergency contact other than parent: _____ Phone: _____

HEALTH HISTORY - TO BE FILLED OUT BY A LICENSED PHYSICIAN

Name of physician _____
Address _____
City _____ State _____ Zip _____

Participant's Height _____ Weight _____ Eye color _____ Hair color _____

Please note if this individual has experienced any of the following conditions:

a. Recent surgery or illness _____ Date: _____
b. Recent broken bones or sprains_____ Date: _____
c. Asthma _____
d. Heart condition _____
e. Known allergy to medication _____
f. Known food allergies _____
f. Bee sting allergy _____ Level of severity _____
Will this child be bringing an Epipen on this program? _____
g. Other childhood diseases _____

Has this person been exposed to a communicable disease in the past 24 hours? _____
If yes, which disease? _____

May this individual take Tylenol if needed? _____ Appropriate dosage: _____
May this individual take Benadryl if needed? _____ Appropriate dosage: _____

Is this participant bringing medication on this trip? _____
If so, please fill out the second page of this document entitled "Instructions for Medication".

Please state any other physical limitations that may inhibit this participant's ability to participate fully in this five day, four night kayaking program: _____
_____

_____ _____
Physician's Signature *Date*

Instructions for Medication

THE TOP PORTION OF THIS FORM MUST BE FILLED OUT BY A PHYSICIAN

Nature of condition requiring medication: _____

_____

_____

Name of Medication	Dosage	Time/s of Dosage

Physician's Signature: _____

IMPORTANT NOTE: All medications must be brought in their ORIGINAL CONTAINERS, not as individual pills.

MEDICAL INSURANCE INFORMATION - TO BE FILLED OUT BY THE PARTICIPANT'S PARENT/GUARDIAN

Company name: _____

Agent: _____ Policy Number: _____

This health history is correct to the best of my knowledge, and my son/daughter has permission to engage in all activities conducted during this program unless otherwise noted. I understand that there are inherent risks involved in any outdoor paddling program. In case of a serious emergency, it may be necessary for a physician to attend to your child before Sultana Projects, Inc. can contact you or your designated physician. Such care can be given only with your authorization for medical treatment. Please sign below to authorize.

I hereby give permission to the physician selected by Sultana Projects, Inc. to hospitalize and secure proper treatment for my child.

Signature: _____ **Date:** _____

Relationship to participant: _____

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MEDICAL AND GENERAL RELEASE FORM

In consideration of SULTANA PROJECTS, INC. allowing me to participate in this kayak program, I agree to release and discharge SULTANA PROJECTS, INC., its employees and agents from any injuries sustained by me as a result of my participation. I agree to indemnify and hold harmless SULTANA PROJECTS, INC., its employees and agents against any liability incurred as a result of such injury or loss. However, I shall have no obligation to indemnify SULTANA PROJECTS, INC. with respect to any injury or loss resulting from, arising out of, or caused by negligence on the part of SULTANA PROJECTS, INC.

_____

Signature of Participant

_____

Signature of Parent or Guardian
(if participant is under 18 years of age)

PERMISSION SLIP

I hereby give permission for (participant's name) _____
to participate in this kayak program with Sultana Projects, Inc. I understand that he/she will be paddling on tidal tributaries of the Chesapeake Bay with Sultana Projects' professionally trained staff members by day and camping ashore at night (Aug. 20 - 21). Additionally, I understand that my son/daughter will be transported by van to various launch sites during the course of this program in a vehicle that will be driven by Sultana staff members.

_____

Signature of Parent or Guardian *Date*

_____

Name of Parent or Guardian (please print) *Relationship (parent/guardian)*

Please return this permission slip and completed medical and general release forms to:

Chris Cerino c/o
Sultana Projects, Inc.
P.O. Box 524
Chestertown, MD 21620

If you have any questions about this program please don't hesitate to contact us at 410-778-5954 or ccerino@sultanaprojects.org.