



## REQUIRED STUDENT FORMS CHECKLIST:

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A lot of information is needed to prepare for your child's SOAR adventure. The following document is the entire set of paperwork required by SOAR. Please use the checklist below to ensure all necessary steps have been completed. You will only need to complete one set of forms per year. Some courses (i.e. SCUBA) require additional forms to be submitted. Feel free to contact our Admissions office if you have any questions at 828-456-345.

- Complete pages 1 – 5, which includes the following sections:
  - Emergency Contact Information
  - Student Medical History
  - Parent Permission to Treat
  - Student Goals Worksheet
  - Picture Release
  - Acknowledgement of Risk
  
- Have the Parent Permission to Treat section (page 2) notarized.  
Note: A notary will be available during registration of NC & WY courses ONLY.
  
- Have the Student Physical Form completed (page 6) by your child's physician.  
Note: This form should be signed by your doctor, indicating a physical has been completed in the past 24 months. Please check with your physician to determine the date of your child's last exam, as you may not need to schedule a new physical.
  
- Attach a copy of your child's immunization records
  
- Attach a copy of your child's insurance card
  
- Attach a photograph of your child (if applicable)

Once completed, please fax ALL information to 828-456-3435 (preferred).

If you do not have access to a fax, you may mail the information to:

SOAR

Attn: Cate Munro

P.O. Box 388

Balsam, NC 28707

After you have submitted the forms, please be sure you have done the following:

- Scheduled your inbrief/debrief times
- Confirmed Travel arrangements
- Submitted final payment (Note: Final payment is due no later than June 1<sup>st</sup>, 2009)



Note: Please print CLEARLY!!!

Failure to complete all portions of this form could result in an injury or compound the damage of an injury.

STUDENT INFORMATION: (Please Print in Ink)

Student Name: \_\_\_\_\_
Age: \_\_\_\_\_
Parent(s) or Legal Guardian(s): \_\_\_\_\_
Primary Contact Phone: \_\_\_\_\_
Address: \_\_\_\_\_
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_
Mother's Home Phone: \_\_\_\_\_
Mother's Cell Phone: \_\_\_\_\_
Mother's Work Phone: \_\_\_\_\_
Student's Physician: \_\_\_\_\_

Date: \_\_\_\_\_
D.O.B. \_\_\_\_\_
Social Security #: \_\_\_\_\_
Father's Home Phone: \_\_\_\_\_
Father's Cell Phone: \_\_\_\_\_
Father's Work Phone: \_\_\_\_\_
Physician's Phone #: ( ) \_\_\_\_\_

EMERGENCY CONTACT INFORMATION:

Contact #1: \_\_\_\_\_
Home Phone: ( ) \_\_\_\_\_ Relationship: \_\_\_\_\_
Cell Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_
Contact #2: \_\_\_\_\_
Home Phone: ( ) \_\_\_\_\_ Relationship: \_\_\_\_\_
Cell Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Please list below the names of those authorized to pick up your child:

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

Please complete the following medical information as thoroughly as you can. This will enable SOAR staff to better administer to your needs.

1. The following may be given by a SOAR staff member if deemed necessary to relieve minor pain and discomfort:

- Tylenol [ ] Yes [ ] No
Benadryl [ ] Yes [ ] No
Ibuprofen [ ] Yes [ ] No
Mylanta [ ] Yes [ ] No
Cough drops or throat lozenges [ ] Yes [ ] No
No medications should be given due to my convictions [ ]

2. Please rate your child's swimming ability: [ ] Advanced [ ] Intermediate [ ] Beginner [ ] Very uncomfortable

3. Date of last tetanus booster? \_\_\_\_\_ Please attach a copy of your child's immunization record.
[ ] My child has not been vaccinated due to my convictions.

4. Has your child evidenced any adverse allergic reaction to bee or wasp stings; or is so predisposed based on family medical history? [ ] Yes\* [ ] No

\* If Yes, please obtain a sting kit or Epi-Pen from your family physician and/or local pharmacist.

5. Is your child allergic to iodine? [ ] Yes [ ] No Is your child allergic to peanuts? [ ] Yes [ ] No
If yes, detail the extent of the allergy and what the reaction looks like: \_\_\_\_\_

6. Is your child on any prescription or over-the-counter medications? [ ] Yes [ ] No
If Yes, please fill out the following completely:

Table with 4 columns: Medication, Dosage, Instructions, Reason for medication. Contains 4 empty rows for data entry.

7. Does your child have a history of any of the following:

- Cardiac or circulatory problems?  Yes  No
- Respiratory problems, including asthma?  Yes  No
- Kidney, bladder or urinary problems, including bedwetting?  Yes  No
- Allergies, including medications or foods (e.g., peanuts)?  Yes  No
- Back, neck, or spinal problems?  Yes  No
- Musculoskeletal problems (e.g. shoulders, arms, legs, feet, etc.)?  Yes  No
- Vision or auditory problems?  Yes  No
- Gastrointestinal problems, including constipation or diarrhea?  Yes  No
- Skin problems?  Yes  No
- Genitalia or reproductive organ problems?  Yes  No
- Have diabetes?  Yes  No
- Head injuries or brain issues (e.g., seizures or convulsions?)  Yes  No
- Psychological issues or treatment?  Yes  No
- Drug or alcohol use or abuse?  Yes  No
- Major surgery or hospitalizations or relevant medical treatment?  Yes  No
- Dietary restrictions or eating disorders?  Yes  No
- Exercise or physical restrictions?  Yes  No
- History of bedwetting?  Yes  No
- Does your child experience motion sickness?  Yes  No
- Does your child have any physical, mental, or psychological condition requiring medication, treatment or special restrictions or considerations while at SOAR or which may limit your child's participation in SOAR activities?  Yes  No

If you checked Yes to any of the above, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Describe any camp activities from which the camper should be exempted for health reasons:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

**Note: Please attach a copy of your insurance card (front and back) with this form.**

Name of Primary Insurance Holder: \_\_\_\_\_

Primary Insurance Holder SS#: \_\_\_\_\_ D.O.B. \_\_\_\_\_

**PARENT PERMISSION TO TREAT**

\_\_\_\_\_ has my permission to participate in SOAR's Program(s) and Course(s) for the year 20\_\_\_\_.

*I hereby authorize SOAR, its designees and agents to stand in loco parentis and authorize any necessary medical care or treatment should I be unavailable to render such consent for my minor child myself. I either have appropriate insurance or, in its absence, agree to pay all costs of rescue and/or medical services as may be incurred on my/our behalf. In addition, I have completed a SOAR Medical Information Form for the above named minor child and certify that all of the information contained on the Medical Information Form is accurate and complete. This Medical Information Form may be photocopied and its content shared with camp staff as necessary. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.*

\_\_\_\_\_  
Signature of Parent or Legal Guardian witnessed by Notary Date \_\_\_\_\_

SEAL

Notary Signature: \_\_\_\_\_ subscribed before me

this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.



# Student Goals Worksheet & Solution Identification Scale

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

Date: \_\_\_\_\_

The staff team working with your child will develop specific "guided growth" goals before the start of the course. This form allows you more input into this process. Please return at least two weeks prior to the course start date. The goals developed will be reviewed with you during the Inbrief.

*I. Please prioritize the strategies below from 1 to 10, with 1 representing the strategies you would most like our staff to focus on during the course and then continue to rank order the other 9.*

### Strategies for dealing with:

- |                     |                              |
|---------------------|------------------------------|
| ___ impulsivity     | ___ communication skills     |
| ___ distractibility | ___ anger management/control |
| ___ memory problems | ___ listening skills         |
| ___ non-compliance  | ___ time management          |
| ___ organization    | ___ goal setting             |
| ___ others: _____   |                              |

### II. Please indicate the degree to which each behavior listed below occurs.

	Not at all	Just a little	Pretty much	Very much	Don't know
1. Tolerates feedback well	_____	_____	_____	_____	_____
2. Shows leadership	_____	_____	_____	_____	_____
3. Accepts praise well	_____	_____	_____	_____	_____
4. Responds well to logical/natural consequences	_____	_____	_____	_____	_____
5. Able to work toward short-term goals	_____	_____	_____	_____	_____
6. Is energetic	_____	_____	_____	_____	_____
7. Stands up for self	_____	_____	_____	_____	_____
8. Is receptive to new ideas	_____	_____	_____	_____	_____
9. Can organize things	_____	_____	_____	_____	_____
10. Can relate ideas verbally	_____	_____	_____	_____	_____
11. Can relate written ideas	_____	_____	_____	_____	_____
12. Can read body language	_____	_____	_____	_____	_____
13. Works well in a group	_____	_____	_____	_____	_____
14. Cares for personal items	_____	_____	_____	_____	_____
15. Responds to encouragement	_____	_____	_____	_____	_____
16. Follows rules	_____	_____	_____	_____	_____
17. Enjoys challenging activities	_____	_____	_____	_____	_____
18. Likes wide range of foods	_____	_____	_____	_____	_____
19. Is a "morning person"	_____	_____	_____	_____	_____
20. Goes to sleep easily	_____	_____	_____	_____	_____
21. Demonstrates patience	_____	_____	_____	_____	_____
22. Responds well to adults	_____	_____	_____	_____	_____
23. Able to de-escalate when frustrated or angry	_____	_____	_____	_____	_____
24. Respectful of others	_____	_____	_____	_____	_____
25. Has kept observation rules	_____	_____	_____	_____	_____
26. Is a "hands on" learner	_____	_____	_____	_____	_____
27. Is a capable listener	_____	_____	_____	_____	_____
28. Practices good hygiene	_____	_____	_____	_____	_____
29. Has "good sense of time"	_____	_____	_____	_____	_____
30. Is successful at school	_____	_____	_____	_____	_____
31. Feels a part of the family	_____	_____	_____	_____	_____
32. Prefers receiving information verbally	_____	_____	_____	_____	_____
33. Is generally compliant	_____	_____	_____	_____	_____
34. Is sensitive to others' needs	_____	_____	_____	_____	_____



**SOAR PICTURE / INFORMATION RELEASE**

I hereby authorize / do not authorize \_\_\_\_\_ to participate in public awareness efforts in the framework of SOAR’s programs. These efforts may consist of advertisements, publications, and presentations in connections with SOAR. I give my permission for any photographs and/or videos of my son/daughter to be used in the following uses: (Please check all that apply)

- Published in SOAR’s course specific online photo gallery
- Utilized in print advertising materials (including brochure, conference displays, ad copy, etc)
- Utilized in online advertising material (website, mass emails, etc.)

OR

- I do not authorize my child’s picture to be used in any SOAR print or online materials nor their website. (If you select this option, please submit a picture of your child for his or her file to ensure this obligation is met)

Also, I give my permission for my son/daughter to participate in a process to help look at the overall effectiveness of our programs. Information compiled will be assimilated as group data and confidentiality will be assured.

- YES       NO

Your child is in no way obligated to participate in any of these efforts. This is the choice of the parent/guardian and the child. Any assistance in this matter will be greatly appreciated.

Signature of Participant \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**PARTICIPANT AGREEMENT AND ACKNOWLEDGMENT OF RISK**

The below signed participant desires to take part in the programs and services offered by SOAR. As a condition to participation, he/she agrees to the following:

1. I acknowledge that the participation in outdoor adventure based activities such as rope course activities, backpacking, rock climbing, mountaineering, caving, horseback riding, mountain biking, whitewater rafting, snorkeling, sea kayaking, and travel in 15 passenger vans 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. I understand that such risks simply cannot be eliminated without jeopardizing the essential qualities of the activity.
2. The risks include, among other things: the possibility of slips, falls, pinches, scrapes, rope burns, twists and jolts that could result in scratches, bruises, sprains, lacerations, fractures, concussions, or even more severe life threatening hazards. During an activity there may be contact with plants, animals, or insects that could create hazards such as stings, allergies, and associated diseases; falling objects, water hazards, collapse, exposure to temperature and weather extremes which could cause hypothermia, hyperthermia, sunburn, or dehydration; improper lifting or carrying; hazards of walking on uneven terrain; being struck by rock fall or other objects dislodged or thrown from above; the risks of falling off the rock or mountain; the use of climbing ropes and equipment, including equipment failure; the forces of nature, including lightning and weather changes; my own physical condition, and the physical exertion associated with this activity; becoming lost; the forces of nature, including earthquakes, rushing water, strong tidal conditions and currents, or cave-ins; travel in remote areas; boat capsizes, collision with objects or other watercraft or accidental drowning; the risk of psychological trauma resulting from being in confined dark spaces; and extended rescue times due to remote locations.
3. Furthermore, I understand SOAR instructors have difficult jobs to perform. They seek to manage risks, but they are not infallible. They might not have full information regarding a participant’s fitness or abilities. They might misjudge the weather, the elements, the terrain, or like factor. Instructors shall rely primarily on their judgment, skills, and training for emergency response and do not carry cell phones or other communication devices into the field with them.



**PARTICIPANT AGREEMENT AND ACKNOWLEDGMENT OF RISK (cont.)**

4. I agree to conduct myself in a manner that is a credit to me and to SOAR. I understand that complying with SOAR policies and procedures dramatically reduce my risks and chance of injury; therefore, I agree to:

- Seek to understand and obey all rules.
- Show respect for the rights and privacy of others.
- Demonstrate cooperation and respect with both staff and peers.
- Take an active role in my personal safety.
- To participate in activities to the best of my abilities.

5. I expressly agree and promise to accept and assume the risks existing in this activity, and agree to be an integral member in my own personal safety team. My participation in this activity is purely voluntary, and I elect to participate in spite of the risks.

6. I certify that I have adequate insurance to cover any injury or damage I may cause or suffer while participating, or else I agree to bear the costs of such injury or damage myself, I further certify that I have no medical or physical conditions which could 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 condition.

7. In the event that I file a lawsuit against SOAR, I agree to do so solely in the state of North Carolina, and I further agree that the substantive law of that state shall apply in that action, without regard to conflict of law rules of that state.

8. By signing this document, I acknowledge that if anyone is hurt or property is damaged during my participation in this activity, I may be found by a court of law to have waived my right to maintain a lawsuit against SOAR on the basis of any claim from which I have released them herein.

I have had sufficient opportunity to read this entire document. I have read and understood it, and I agree to its terms.

Signature of Participant: \_\_\_\_\_

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

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) being permitted by SOAR to participate in its activities and to use its equipment and facilities, I further agree to indemnify and hold harmless SOAR from any and all claims which are brought by, or on behalf of Minor, and which are in any way connected with such use or participation by Minor.

Parent or Guardian: \_\_\_\_\_

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

Date: \_\_\_\_\_



## PHYSICIAN VERIFICATION OF PHYSICAL EXAM

SOAR is a wilderness and adventure program for youth ages 8-18 who are diagnosed with Learning Disabilities and Attention Deficit Disorders. Students participate in a variety of activities including backpacking, horsepacking, llama trekking, rock climbing, whitewater rafting, canoeing, snorkeling, sea kayaking, fishing, sea dooing, day hiking, caving, mountain biking, throwing tools, and primitive skills. Courses are 10-26 days in length and involve camping and sleeping in the outdoors in a wide variety of environmental conditions.

Name of student: \_\_\_\_\_

1. Does this student have any physical condition requiring restriction(s) from SOAR activities?  
 Yes       No

If yes, please describe the condition and restriction(s) below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Does the student have any current or on-going treatment or medications?  
 Yes       No

If yes, please describe the treatment and/or medication below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. *Please attach a copy of this student's immunization record.*

As physician for \_\_\_\_\_, I verify that this student has had a  
(name of SOAR student)  
physical examination within the last 24 months. Date of exam: \_\_\_\_\_

Printed name of physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Signature of physician: \_\_\_\_\_