# 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

Name______________________________________________ Social Security No. ______________________________
Last First Middle Preferred.

**Address**

____________________________________________ Phone Number: __________________________
Street (include apt., box, etc.) E-mail Address:__________________________

____________________________________________ Cell Phone: ______________________________
City State Zip

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: __________________________________

**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 Guardian Information

(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:** (*Please attach a photocopy of both the front and back of your insurance card)*

**DO YOU HAVE INSURANCE?** **Yes** ☐ **No** ☐

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 √ yes or no -- If yes, describe below | Y | N | # | Please √ 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 | | | 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 √ 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? | ☐ | ☐ |
| 2 | Are you currently in counseling or treatment with a therapist, psychiatrist, psychologist, or prescribing physician? | ☐ | ☐ |
| 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?** | ☐ | ☐ |
| 4 | Please check the appropriate responses that indicate the reason(s) for counseling:<br>☐ **Academic/Career** ☐ **Divorce** ☐ **Family Issues** ☐ **Maintenance of Medication**<br>☐ **Substance Abuse** ☐ **Depression** ☐ **Eating Disorder** ☐ **Suicide** ☐ **Other** ________________ | | |
| 5 | Name of current (or most recent) therapist ______________________________<br>Telephone # (_____)______________ FAX # (_____)______________ email ________________________ | | |
| 6 | Name of prescribing physician ______________________________<br>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 a primary (parent/guardian) and secondary person 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—

I have read, understand, accept and agree to abide by the rules, policies and guidelines established by WILL. I understand that the relationship between me (my child/ward) and WILL 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 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.

I give WILL permission to use my (my child's/ward's) name, contact information, picture, and quotes in promotional materials, fund raising materials, websites, and press releases.

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 (except to provide medical care) will remain confidential.** 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.

**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.
1758 Park Road, N.W.
Washington, D.C. 20010
Attn: Stephen H. Abraham
(tel) 202-319-2765
(fax) 202-483-1206