# Children of the Earth Foundation

## COYOTE TRACKS PROGRAMS
## Registration 2018

| For Office Use Only | |
|---|---|
| XL | Medical |
| Q | Waiver |
| Confirm | Paid |

Family Name(s) ________________________________________

Home Address _____________________________________________________

City__________________________ State_____Zip_________________ Country_____

Best Phone ___________________ Guardian Email _______________________

| Program Title | Date | First and Last Name | Age | Cost |
|---|---|---|---|---|
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| ***All programs require a $200 deposit per participant, except Bridge Programs, which require a $25 deposit. Deposits are due with registration.*** | | **Total $** | | |

- **Bridge Programs** *are for staying at Coyote Tracks between programs.*
  - UNACCOMPANIED MINORS: $95/person - Includes supervision, camping, meals, & activities.
  - FAMILY: $50/person - Includes camping, meals and some camp activities, but you must supervise your child.

- **Payment Information**

  *You may pay by check, credit card, or PayPal: (use info@cotef.org, or go to www.cotef.org/payments).*

Make checks payable to *COTEF*. The balance is due two weeks prior to camp and is required to ensure your place in camp. Call us for credit or debit card payments. Your balance will be automatically charged two weeks prior to camp on the credit card provided unless we hear otherwise from you. Please see our cancellation policy for information on refunds and credits.

*All payments in US Dollars only, please!*

■ **Emergency Contact Information**

1) Parent/Guardian Name ______________________ Work Phone _____________

Cell Phone ________________________________ Email __________________

2) Parent/Guardian Name___________________________ Work Phone ____________

Cell Phone ________________________________ Email____________________________________

3) Another Emergency Contact____________________________ Relationship____________________

1st Phone ____________________________ 2nd Phone ________________________________

■ **Travel Information -** *Detailed travel info will be sent upon receipt of your registration. Leave blank if you don't know your means of travel at the time of registration.*

Cell phone during travel _________________________

I/we plan to arrive and leave by:

___Car

___Train to Patterson, NY- please pick us up at the train station. *(NY summer programs only)*

___ Bus to Waretown Plaza- please pick us up at the bus stop. *(NJ Weekend programs only)*

___Other_________________________________________________________________________

■ **School Store Tab**
There will be items available for purchase that may include snacks, knives, books, apparel, etc. All tabs must be paid by the last day of the program.

## Once You Are Registered

**Look for the Confirmation Email**
Upon receipt of your registration, you will receive a confirmation and our handbook that has information on what to bring and how to get there.

You are not fully registered until we receive all parts of this registration. Please be sure you have completed the entire form and that each person, regardless of age, has a completed medical form page.

***Thank you!***

# MEDICAL FORM

**Each participant must send a completed form- make additional copies as needed. For NY Programs each minor must have a completed medication form *signed* by their physician. For all other programs this page may be completed by the parent or guardian.**

**(Adults may leave their immunization sections blank)**

Name__________________________________________________ Date of Birth_______________________

Gender: M F

Medical Insurance Company______________________________ Policy Number___________________________

- **Indicate Dietary Preference**

  Omnivore Vegetarian Vegan Other:___________________________________

- **Medical History**

Please list any:

Allergies to Food(s):___________________________________________________________________

Allergies to Medication(s):______________________________________________________________

Other Allergies:__________________________________________________________________

Describe reaction and treatment of these allergies:_____________________________________________________

_______________________________________________________________________________________________

Please check all that apply to the participant of which we should be aware:

_______Recent injury or illness

_______Chronic or recurring illness/condition

_______Frequent headaches

_______Wear glasses or contacts

_______Frequent ear infections

_______Ever had seizures

_______Ever had high blood pressure

_______Have diabetes

_______Have asthma

_______History of sleepwalking

_______History of bed-wetting

_______Eating disorder

_______Diagnosed with ADD or ADHD

_______Emotional/psychological difficulties for which professional help was sought

_______Other medical conditions

Please explain all items that are checked or any other issues for which you would like us to be aware:

_______________________________________________________________________________________________

_______________________________________________________________________________________________

- **Immunization Voucher**

Please check one:

☐ My child is fully immunized.

☐ My child is exempted from immunization for medical reasons.

☐ My child is exempted from immunization for religious reasons.

- **Meningococcal Meningitis Vaccination Response Form ( for NY programs only)**

New York State Public Health Law requires the operator of an overnight children's camp to maintain a completed response form for every camper who attends camp for seven (7) or more nights. Check appropriate box:

☐ My child will not attend seven or more nights of overnight camp.

☐ My child has had the meningococcal meningitis immunization (Menomune™) within the past 10 years. Date received_________________

☐ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will not obtain immunization against meningococcal meningitis disease.

■ **Medications**

**(For NY programs it is *required* that this be completed by each minor's physician, other programs may be completed by parent or guardian. Make additional copies as needed)**

Participant Name__________________________________________

Physician Name____________________________ Physician Phone____________________________

Physician Address___________________________________________________________________________________

**Prescribed Medications**

*I have prescribed the following medications to* ____________________________________*(minor's name) and hereby order that they be dispensed to the above minor by qualified staff of The Children of the Earth Foundation:*

Medication:_______________________________________ Dose______________________________________
Specific time(s) take each day or condition______________________________________________________________

Medication:_______________________________________ Dose______________________________________
Specific time(s) take each day or condition______________________________________________________________

**Over the Counter Medications**

*The following may be given as symptoms require and should be administered as indicated for the minor's age or weight on the manufacturer's instructions.*

_______ Acetaminophen (Tylenol)
_______ Ibuprofen (Advil)
_______ Pseudophedrine (Sudafed)
_______ Diphenhydramine (Benadryl)
_______ Cough Drops
_______ Dextromethorphan (Robitussin DM)
_______ Loperamide (Imodium A-D)
_______ Antacid (Tums)
_______ Anbesol
_______ Calamine Lotion

_______ Topical antibiotic cream
_______ Hydrocortisone 1% cream
_______ Aloe or Burn Spray
_______ Antifungal Spray or cream
_______ Other_____________________________
__________________________________________
__________________________________________
__________________________________________
____________________________

Physician's Name ____________________________ Physician's Signature______________________
Date____________________________________________*(For programs in NY State only)*

Guardian's Name __________________________________Guardian's Signature______________________
Date_________________

# Children of the Earth Foundation

**Conditions of Participation/Waiver**

RELEASE AND WAIVER OF LIABILITY: In all programs conducted by The Children of the Earth Foundation (hereinafter COTEF), reasonable care is taken to prevent serious injuries and to minimize accidents. I am fully aware that survival, tracking, awareness and philosophy training, even under the safest conditions, has inherent dangers and I hereby accept any and all responsibility for, and assume the risk of any and all injury or damage to my person or dependent children that might arise directly or indirectly as a result of participation in any COTEF program. I hereby expressly release, discharge and hold harmless from any liability whatsoever, COTEF and all employees and volunteers in their capacity as representatives of COTEF, expressly including the Board of Directors of the COTEF, except for injuries caused intentionally, or by willful misconduct.

PROPERTY LOSS: I understand COTEF is not responsible for a participant's personal property that is lost, damaged or stolen during the course of a COTEF program.

INSURANCE: I understand that it is my responsibility to provide for my own, and any other members of my family if applicable, accident and health coverage while participating in COTEF programs. COTEF does not provide any accident and health insurance for its participants.

MEDICAL RELEASE: I authorize COTEF, as my agent, to give consent to surgical or medical treatment by a licensed physician or hospital when the physician deems such treatment necessary and I cannot be contacted within a reasonable time or I am not otherwise able to give such consent. I authorize COTEF to give first aid, CPR or other treatment by a qualified staff member.

PHOTOGRAPHS: I authorize COTEF to have and use photographs or video of my child/ren or myself as may be needed for its records or public relations projects.

ACCEPTANCE: I certify that I am familiar with the contents of this release, that I have read and understand the same, and that it is my intention by signing this release that the same be binding not only on me, but on my heirs, administrators, executors, successors, and assigns.

**Signature of all adult participants and guardians of minor participants:**

Signature__________________________________________________ Date____________________

Signature__________________________________________________ Date____________________

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**Send completed registration packet with deposit to:**

info@cotef.org

*or* PO Box 301, N. Pomfret, VT 05053

*or* fax to: (888) 479-2481

Upon receipt you will receive email confirmation and a packet including directions to camp, equipment lists and other helpful information to help prepare for camp. If you have further questions, contact us at (609) 971-1799 or info@cotef.org