



**ADIRONDACK TRAIL IMPROVEMENT SOCIETY, INC.**  
**P.O. Box 565, Keene Valley, NY 12943**

**ATIS Junior Program Health Information, Waiver and  
 Permission to Treat Form**

**This form must be submitted before the hiker begins the first hike of the summer.**

Participant's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Are there allergies? (Specify) _____ _____	<b>If the hiker requires an Epi-Pen, the counselor must know where the Epi-Pen is or carry the Epi-Pen during the hike.</b>
Are there any medications that would need to be taken while participating? _____ _____  Child must be capable of self-medicating since counselors are not permitted to administer medications.	<b>Please list any additional conditions or concerns we should know about your child's ability to participate in the program.</b> _____ _____

**I hereby give ATIS personnel permission:**

1. To have access to my son / daughter's medical information included on this form; to provide first aid during the hike/ ATIS sponsored activities; to select medical personnel for the purpose of ordering X-rays, routine tests, or treatment for the listed participant; to make relevant medical information available to medical personnel.
2. In the event that I cannot be reached in an emergency, I hereby give permission to the health care provider selected by ATIS to hospitalize, secure proper treatment for, and order injections and /or anesthesia and/or surgery for the child named above.

This health information is correct to the best of my knowledge. I believe my child to be physically and emotionally capable of participating in all ATIS activities except as noted. As parent/guardian of the above-named child, I also acknowledge that I am aware of the potential dangers of some activities (steep trails, rough waters, sudden changes in weather, distance from medical personnel and facilities, lack of cell phone or other communication, etc). I understand that the leaders of ATIS activities, while trained in first-aid are not health professionals and are not qualified to give professional medical treatment. I accept that it is my responsibility to understand the risks of any activity my child signs up for and not to allow participation beyond the child's capabilities. I also waive any and all claims that might otherwise arise against ATIS or its personnel as a result of my child's participation. I understand that the information on this form may assist ATIS personnel, but that its submission does not impose any legal responsibility on ATIS or its personnel.

**Signature of parent or guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**Insurance: Each participant is responsible for medical expenses.**

Does the insurance company require preauthorization? Y N Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_ Billing address of Ins. Company: \_\_\_\_\_

Group # \_\_\_\_\_ Telephone # \_\_\_\_\_

**CONTACT INFORMATION**

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

Local Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**If not available in an emergency, notify:**

Name/ Relationship \_\_\_\_\_ Phone \_\_\_\_\_