

## **Community Connections Wilderness Adventure Information Forms**

**Parents of students participating in the Long Trail Backpacking, Maine Canoe & Backpacking and Beginner Backpacking Courses, please read this packet carefully and return appropriate forms.**

Congratulations on the decision to participate in Community Connections wilderness adventures. We are extremely excited about this summer's adventures and look forward to having you as part of it. Enclosed in this packet you'll find detailed trip information and several forms designed to make each trip safe and enjoyable. We have tried our best to keep all forms clear and simple while still obtaining the information that we need to ensure a safe wilderness experience. Please read through everything carefully. After reviewing all of the enclosed materials, please call us with unanswered questions (802-223-3456). We're looking forward to seeing you this summer!

**To Complete Your Registration:** Parents and participants should carefully read and thoroughly complete all the forms in this packet. Please mail all the forms (see list below) back to us as soon as possible. This will help us to plan the best adventure possible for the group. We recommend keeping a copy of the forms for your files. Complete & mail to Community Connections 73 Main St #33, Montpelier VT 05602.

**Course Expectations:** Community Connections does not require prior experience for any of its wilderness based courses. We do expect a desire to try new things and face new challenges as well as a willingness to cooperate with the group. Participants are expected to support each other through challenges and share camp chores with the help and guidance of the instructors. Enthusiasm, commitment, and a positive attitude will make this trip an adventure of a lifetime!

**Getting in Shape:** Participants do not have to be in tip top shape to take part in these courses. However, we suggest getting into a simple routine of exercise at least a month before the start of the trip. Wear hiking boots as much as possible to break them in, walk whenever possible, and even take a few hikes with a full backpack on to get used to the feel of carrying that extra weight. The instructors attempt to plan the itinerary to suit the experience of the group, but the physical preparation of participants will help them and the group when the trail gets a bit challenging.

**Food:** Participants eat three full meals a day, including plenty of snacks. We provide fresh food, probably similar to what is eaten at home, although we might ask participants to try something new. Favorite meals include pastas, burritos, stir-fry, bagels and cream cheese or peanut butter and jelly, dry and hot cereal, cookies, granola, fruit, and hot chocolate for chilly evenings and mornings. We easily accommodate most dietary restrictions; let us know in advance so we can plan accordingly. All the participants help prepare and clean up after meals. They learn to use a camp stove and perhaps to make some new creations to impress family at home!

**Money:** Participants will not need any money during the trip.

**Tents:** Community Connections will provide three or four-person backpacking tents. Boys and girls never share tents, a policy strictly enforced by instructors. On occasions that the group might sleep together under a large tarp or in a backcountry shelter, the instructors would ensure privacy for changing and an appropriate sleeping arrangement.

**Transportation:** During the trip, participants will be transported to and from trailheads, paddling locations, and other activity areas in 7-passenger vans driven by the instructors and other support personnel. We spend as little time as possible driving between activities to maximize our time in the wilderness; most rides are 20 minutes to an hour, with three hours being the longest.

**Medications:** On the Confidential Health Questionnaire, carefully and completely list all prescription and over-the-counter (OTC) medications your child takes, complete with dosage, frequency, side effects, and the condition for which it is prescribed. Instructors also carry medications in their First Aid Kits. On the Health Questionnaire, please note which First-Aid kit medications are appropriate to administer to your child, if necessary. Last, a licensed medical personnel must also list and sign off on prescription medications that your child will take during the trip. Community Connections instructors are responsible for carrying and managing ALL medications during the trip for the safety of your child as well as the other participants. This includes painkillers and commonly used OTC drugs. Send your child's medications in the pharmacy's labeled bottle with the full label attached. Check in with the instructors on the first day of the trip to clarify any questions about the medications. During a Teen Wilderness Adventure, your child will continue taking any medications he or she does on a regular basis.

**In Case of Emergency:** If an emergency arises at home and you must reach your child, call the Community Connections Central Office at 802-223-3456

**COMMUNITY CONNECTIONS  
BACKCOUNTRY PROGRAMS  
TRIP POLICIES FORM**

Prior to the start of the program, the participant and parents/guardians must understand and agree to abide by the following policies and regulations. These policies and regulations are for the safety of the individual, the group, and the organization.

**The Possession and/Or Use of Tobacco Products:** The possession or use of any and all tobacco products is not acceptable during any of our programs. If individuals are in possession of any tobacco product after the start of the program, the participant will be sent home immediately.

**The Possession and/Or Use of Alcohol Products or Illegal Drugs:** The possession or use of any and all alcohol products or illegal drugs/drug paraphernalia is not acceptable during any of our programs. If individuals are in possession of any alcohol products or illegal drugs after the start of the program, the participant will be sent home immediately at parent expense and/or turned over to the legal authorities. In addition to being illegal for minors, alcohol and drugs can be very dangerous in the remote environments where we travel.

**The Possession and/or Use of Weapons:** The possession or use of any and all firearms or knives is not acceptable during any of our programs. If individuals are in possession of any firearm or knife after the start of the program, the participant will be sent home immediately at parent expense.

**Sexual Behavior/Coupling:** Sexual activity and harassment is prohibited on all Community Connections programs. Inappropriate sexual behavior and/or harassment is grounds for a participant to be sent home immediately at parent expense. Equally important is the effect on the group of pairing off or "coupling" students. This behavior often divides the group and creates cliques, possibly resulting in tension within the group and creating an uncomfortable situation for other participants. This situation may result in a student or students being sent home.

**Cell Phones and other Electronic Devices\*:** The possession or use of cell phones, mobile web devices, iPods, mp3players, portable radios or CD players, portable gaming devices, or other entertainment-related devices is not permitted. Electronic devices prevent participants from being fully engaged in their outdoor experience, and, these devices may be damaged or destroyed in outdoor environments. These devices should be left at home, and staff will confiscate any device found in the field and return it at the end of the trip.

\*This policy does not apply to digital cameras. Personal cameras are brought at owner's risk.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**COMMUNITY CONNECTIONS**  
**Confidential Health Questionnaire**  
**Medical Screening**

In order to provide a positive experience for our participants, Community Connections collects medical information via this questionnaire and licensed medical personnel sign-off. We will be offering a range of programs varying in environmental conditions, physical difficulty, and access to emergency medical services. Thus, in an effort to minimize risk for participants, Community Connections utilizes the information gathered to better care for each participant and make well informed decisions in case of emergency.

**Instructions for Completing the Confidential Health Questionnaire**

1. Please fill out all forms honestly and thoroughly. All medical information given is treated as confidential and will only be shared with Community Connections field instructors.
2. Forms A and B are to be filled out by the parent/guardian.
3. Please completely list all prescription and over-the-counter medications your child takes, complete with dosage, frequency, side effects, and the condition for which it is prescribed. Please attach another page if necessary.
4. Forms C and D are to be filled out by a medical professional. Acceptable licensed medical personnel are restricted to Doctors (MD), Registered Nurses, (RN), Licensed Practitioner Nurses (LPN), and Physicians Assistants (PA).

**Community Connections requires that each child has had a physical examination prior to attendance. If your child has had a physical within 2 years of the trip start date, that physical will fulfill Community Connections requirement as long as the examining physician completes and signs Forms C and D of the Health Questionnaire.**

**Before sending back paperwork, please make sure:**

- A parent/guardian has fully completed Forms A and B.
- The licensed medical professional has fully completed Forms C and D.

**Confidential Health Questionnaire**

**Form A: Parent/Guardian must complete Forms A and B for the child participating in Community Connections Trip.**

Participant Name: \_\_\_\_\_ Trip \_\_\_\_\_

Age at Trip Start: \_\_\_\_\_ Male/Female: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone Number: (day) \_\_\_\_\_ (eve) \_\_\_\_\_  
(cell) \_\_\_\_\_

Medical Insurance # \_\_\_\_\_ Policy # \_\_\_\_\_ Carrier's Name: \_\_\_\_\_

**DIETARY RESTRICTIONS: Please be specific** (vegetarian, no red meat, vegan, lactose intolerant, **food allergies**, strong food dislikes, etc.)

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

**IF YOUR CHILD IS BRINGING NON-PRESCRIPTION (over-the-counter) MEDICATIONS, PLEASE COMPLETE AND SIGN THIS SECTION.** (Medications must be in original containers per state law.)

Medication \_\_\_\_\_

Dosage (amt/time of day) \_\_\_\_\_ Initiated(month/year) \_\_\_\_\_

Side Effects \_\_\_\_\_

The above information and directions for assistance of all non-prescription medications is complete and correct. I authorize Community Connections staff to use their discretion in managing the above medications as indicated.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**PERMISSION TO ADMINISTER OVER-THE-COUNTER MEDICATIONS DURING COMMUNITY CONNECTIONS PROGRAM:**

I authorize the Community Connections instructors to assess the need for and appropriately administer the below checked medications:

- Advil(ibuprofen)                       Benedryl (diphenhydramine)
- Tylenol (acetaminophen)                       Pepto Bismol

**Parent/Guardian Signature:** \_\_\_\_\_

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

**Form B: Parent/Guardian must complete pages Forms A and B for the child participating in Community Connections activity.**

**MENTAL, EMOTIONAL, SOCIAL HEALTH QUESTIONNAIRE**

**1. Has the child ever been treated for emotional or behavioral difficulties or an eating disorder?** \_\_\_\_\_

**2. During the past 12 months, has the child seen a professional to address mental/emotional health concerns?** \_\_\_\_\_

**3. Has the child had a significant life event that continues to affect the child's life?**

(History of abuse, death of a loved one, family change, new sibling, survived a disaster, others.) If you answered **YES** to any of questions #1-3 above, please explain in the space below. Attach a separate sheet if needed \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If there is anything specific you think we should know about this child's medical background, please explain here. Attach a separate sheet if necessary.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE READ CAREFULLY! Participants and Parent/Guardians) must read and sign below.**

**Participant acknowledgement of accuracy and understanding.** By signing this form, I am declaring that, to the best of my knowledge, I have completed the questionnaire accurately. I also understand that my knowingly filling out the form inaccurately, or by withholding pertinent information about my health, I could potentially be increasing the risk to myself or others.

**Consent to accept aid.** By signing this form, I am giving consent and permission for Community Connections staff to provide medical care to me or my child, to transport me or my child to a medical facility or to seek the aid of emergency medical services as deemed appropriate. I further authorize Community Connections staff, to render whatever treatment they consider necessary for my or my child's health, and I agree to pay all costs associated with that care and transportation.

Participant's Name (printed): \_\_\_\_\_

Participant's signature: \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_

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

**IF CHILD IS BRINGING *PRESCRIPTION* MEDICATIONS ON A COMMUNITY CONNECTIONS TRIP, PLEASE COMPLETE AND SIGN THIS SECTION.**

(Medications must be in original containers per state law.)

Medication \_\_\_\_\_ Condition \_\_\_\_\_  
Dosage(amt/time of day) \_\_\_\_\_ Initiated(month/year) \_\_\_\_\_

Side  
Effects \_\_\_\_\_  
\_\_\_\_\_

Medication \_\_\_\_\_ Condition \_\_\_\_\_  
Dosage(amt/time of day) \_\_\_\_\_ Initiated(month/year) \_\_\_\_\_

Side  
Effects \_\_\_\_\_  
\_\_\_\_\_

Medication \_\_\_\_\_ Condition \_\_\_\_\_  
Dosage(amt/time of day) \_\_\_\_\_ Initiated(month/year) \_\_\_\_\_

Side  
Effects \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

The above information and directions for assistance of all prescription medications is complete and correct. I authorize Community Connections staff to manage the above medications as indicated.

**Parent/Guardian Signature:** \_\_\_\_\_

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

***Licensed medical provider (MD, RN, LPN, or PA) must complete Forms C and D for the child participating in a Community Connections activity.***

**Form C: HEALTH HISTORY QUESTIONNAIRE**

**Patient Name** \_\_\_\_\_ **DOB** \_\_\_\_\_

**Has the child: Yes No**

**1. Experienced an asthma attack at any time in his/her life?** (Asthma can potentially be affected by exercising at altitude, in dry air, extreme cold, etc.) \_\_\_\_\_

**2. Ever been diagnosed with Type I or Type II diabetes?** (A diabetic can easily become dehydrated in backcountry environments. Further, long, arduous days/hikes can lead to hypoglycemia, etc.) \_\_\_\_\_

**3. Ever visited a medical professional for a serious allergic reaction, or ever been given a shot of epinephrine for an allergy or anaphylaxis?** (Some people are allergic to stinging insects; nut products or other food products which a co-participant might be carrying or may be included in a meal prepared by Community Connections staff; iodine, which might be used to treat drinking water and/or clean wounds, etc.) \_\_\_\_\_

**4. Ever received medical treatment for angina, a heart attack, or any type of heart disorder/disease?** \_\_\_\_\_

**5. Ever been diagnosed with or is he/she currently being treated for high blood pressure?** (The environment and workload associated with Community Connections wilderness courses can sometimes affect BP and/or the efficiency of some BP medications.) \_\_\_\_\_

**6. Ever seen a medical professional following a seizure, or is he/she currently being treated for any type of seizure disorder?** (Some seizures are triggered by fatigue and dehydration [which can occur following a long hike], significant change in diet, stress, etc.) \_\_\_\_\_

**7. Is there anything else you think we should know about child's medical background?** (i.e., anything that could affect his/her safety or ability to participate fully?) \_\_\_\_\_

**8. Is child up-to-date with the following immunizations: Hepatitis B, Mumps, Measles, Rubella, Polio, Diphtheria, Tetanus?** \_\_\_\_\_

**Date of last tetanus:** \_\_\_\_\_

**9. Had the required physical examination within two years of trip start date?** \_\_\_\_\_

If you answered **YES** to any of questions **#1-7** above, please answer the following as well:

**HEALTH HISTORY QUESTIONNAIRE (continued)**

If you answered **YES** to any of questions #1-7 above, please answer the following:

**Patient Name** \_\_\_\_\_ **DOB** \_\_\_\_\_

- He/she was diagnosed with \_\_\_\_\_ in the last year.
- He/she has visited the emergency room in the last year due to \_\_\_\_\_.
- He/she has had to use epinephrine following an asthma attack/allergies or anaphylaxis in the last year? \_\_\_\_\_
- Will he/she be bringing/carrying epinephrine on the outing? \_\_\_\_\_
- What is he/she allergic to? \_\_\_\_\_
- How often does he/she use an inhaler to treat asthma or wheezing? \_\_\_\_\_
- Does he/she have poor circulation due to diabetes? \_\_\_\_\_
- Will he/she be carrying insulin or wearing an insulin pump during this trip? \_\_\_\_\_
- Is he/she able to exert him/herself for more than 60 minutes without experiencing angina (chest)pain? \_\_\_\_\_
- Is he/she currently taking medication for seizures? \_\_\_\_\_
- Has he/she experienced a seizure in the past year? \_\_\_\_\_
- Is his/her blood pressure currently under control (i.e., systolic under 140 and diastolic between 60 and 100)? \_\_\_\_\_
- Is there anything else you think we should know about this child's medical background? Attach a separate sheet if necessary.

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**Form D: To be completed by Licensed medical provider (MD, RN, LPN, or PA) for the child participating in Community Connections activity.**

**Patient Name** \_\_\_\_\_ **DOB** \_\_\_\_\_

Name of Medical Provider: \_\_\_\_\_

Phone: \_\_\_\_\_

Provider Address: \_\_\_\_\_

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

**PROVIDER ORDERS FOR PRESCRIPTION MEDICATION** (For Community Connections to manage prescription medications, orders must be completed and signed by a physician AND medications must be in original containers per state law.)

**Is this child on any prescription medications?** ( ) Yes ( ) No

Please list:

Medication \_\_\_\_\_

Condition \_\_\_\_\_ Dosage (amt/time of day) \_\_\_\_\_

Initiated(month/year) \_\_\_\_\_

Side

Effects \_\_\_\_\_

Medication \_\_\_\_\_

Condition \_\_\_\_\_ Dosage (amt/time of day) \_\_\_\_\_

Initiated(month/year) \_\_\_\_\_

Side

Effects \_\_\_\_\_

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Will the child be carrying an epinephrine auto-injector or rescue inhaler during the trip?**

( ) Yes ( ) No

**If YES, I verify that the child has the knowledge and skills to safely possess and use the epinephrine auto-injector or asthma rescue inhaler *listed above* in a wilderness setting.**

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_