



# Kodiak Pathways Application Youth Experiential Summer Session

## Consent To Treatment and Limitations and Waiver of Liability

In consideration of my child's acceptance in the Kodiak Pathways Youth Experiential Summer Session, I hereby release and forever discharge, on my behalf and on behalf of my minor child, Kodiak Pathways, LLC, its agents, employees, officers and directors from all claims, demands, actions, judgments and executions of any kind which arises out of my child's participation in the aforementioned experiential session.

I, the undersigned, have read this release and understand all of its terms. I execute it voluntary and with full knowledge of its significance.

I hereby authorize Kodiak Pathways, LLC, its agents, employees, and staff members, to provide authorization, confirmation, emergency, and/or medical treatment for my child at any medical facility, should the need arise. I understand this will be done on my behalf should Kodiak Pathways, LLC be unable to contact me at time of said emergency. I acknowledge that I am fully and ultimately responsible for payment of said treatment.

All prescribed medications must be held in the custody of Kodiak Pathways, LLC and will be dispensed by lodge staff. I agree to provide sufficient prescribed medications taken by my child for the term of the session.

I  do  do not agree to have my child photographed. I understand these photos may be used for presentation purposes.

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Parent or Legal Guardian's Name (printed)

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Signature

Date

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Phone: Day

Night

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Phone: Emergency

Student's Name: Last First MI

Address: Street City

State Zip Telephone

Student's Age: \_\_\_\_\_

*Student's Health Form*

To be completed by student's parent or guardian.

Drug Allergies \_\_\_\_\_

Food Allergies \_\_\_\_\_

Bee, Wasp, Hornet, Insect, Shellfish Allergies \_\_\_\_\_

Last Tetanus Immunization Date \_\_\_\_\_

Physical Limitations or Restrictions \_\_\_\_\_

Chronic Illness \_\_\_\_\_

Surgeries \_\_\_\_\_

Injuries \_\_\_\_\_

**Current Prescribed Medications** \_\_\_\_\_

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> Asthma      | <input type="checkbox"/> Blood Disorder  |
| <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Heart Disease   |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Seizures    |  |

**Insurance Company:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_

**Group Number:** \_\_\_\_\_

**Claims Phone Number:** \_\_\_\_\_

**Policyholder (name):** \_\_\_\_\_

**Physician Telephone:** \_\_\_\_\_

**Dentist Telephone:** \_\_\_\_\_

I hereby authorize the release of medical information regarding (student's  
name ) \_\_\_\_\_ to Kodiak Pathways, LLC

**Parent or Guardian** \_\_\_\_\_  
**Signature** **Date**

As space is limited, in order to secure student enrollment, registration and deposit deadline is May 15, 2008. Applications received after May 15, 2008 will be considered on a first come, first served basis. Total fee is \$4,900.00 (50% deposit required at time of application, balance due not later than June, 10 2008). Please make checks payable to Kodiak Pathways and forward along with application to:

**Kodiak Pathways  
P.O. Box 295  
Thompson Falls, MT 59873**