

# Application for Father/Son Camp July 14-16, 2023

Send To: **Turtle Island Preserve** • Attention: Father/Son Camp • 2683 Little Laurel Rd. Boone, NC 28607

Have questions? Contact us at: Email - [wotswild@gmail.com](mailto:wotswild@gmail.com) or Call/Text - (423)-292-9926



**Tuition: \$425 per participant (no charge for children ages 3 and under)**

I grant permission for my child to participate in all Turtle Island Camp activities. I fully understand that my child will be learning to use fire and sharp tools in order to learn certain skills. There will be hiking, swimming, interacting around horses and other farm animals, and playing in a rough wilderness environment. I fully understand that certain accidents may occur and I agree not to hold Turtle Island Preserve Camp, leaders, or staff liable in anyway whatsoever. In case of emergency, I authorize Turtle Island Preserve Camp staff to provide and or seek first aid, hospital, and professional care for me and or my child.

Parent Signature: \_\_\_\_\_ Printed name: \_\_\_\_\_ Date: \_\_\_\_\_

Participant Name: \_\_\_\_\_  
first middle last age

Participant Name: \_\_\_\_\_  
first middle last age

Participant Name: \_\_\_\_\_  
first middle last age

Participant Name: \_\_\_\_\_  
first middle last age

Home Address: \_\_\_\_\_

*\* This is the address all primary correspondences will go to, unless otherwise indicated.*

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Father's Cell: \_\_\_\_\_ Son's Cell: \_\_\_\_\_

Father's Email: \_\_\_\_\_ Son's Email: \_\_\_\_\_

Name of Emergency Contact Person (Other than Father): \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

Describe your and your son's swimming level: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Effective Dates \_\_\_\_\_ to \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Contact # \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

1.) Why do you want to come to Turtle Island Preserve and what do you hope to get out of your experience?

---

---

2.) What activities, primitive skills, and crafts are you most excited about participating in and learning about?

---

3.) If you and your child are first time campers, how did you learn about Turtle Island Preserve?

---

4.) Do you or your child have any dietary restrictions/food allergies, medical conditions, pre-existing allergies, or currently taking any medications ? (If so, please list in detail) \_\_\_\_\_

---

5.) Does your child have any challenging behaviors we should be aware of? \_\_\_\_\_

---

(Use reverse side of page if you need to elaborate on any details, concerns or needs that are not covered above)

# Turtle Island Preserve, Inc. Agreement of Participants & Liability Release

I, the undersigned Participant, in **consideration** of the Turtle Island Preserve, Inc. instruction and experience in which I have voluntarily chosen to receive and participate, acknowledge and agree that:

1. I will be given instructions/materials designed to maximize the greatest practical degree of my health and safety.
2. I share in the responsibility for my health and safety during my participation in Turtle Island Preserve, Inc. activities and I voluntarily assume this responsibility.
3. I acknowledge and accept the risks of embarking on this project and adventure including potential damage to or loss of my property and damage to my person or loss of my life.
4. I am acting in reliance upon my **own judgment** and ability to determine if I am qualified to participate in these activities.
5. I certify that I am medically, physically, mentally, and emotionally **healthy** - sufficient to participate in the Turtle Island Preserve activities.
6. I certify that no **promise**, warranty, or representation has been made to me other than as set out in this written agreement concerning safety or liability.
7. I hereby bind myself, my guardians, attorneys-in-fact, heirs and assigns to **release**, make no claim against, and indemnify Turtle Island Preserve, Inc., its owner, employees, instructors and agents from all liabilities, losses, costs, damages, claims or causes of action of any kind arising from my participation in these activities or the negligence or intentional acts of the Turtle Island parties.

To **assist** me in executing my responsibilities, I agree to:

- A. Cooperate** in assimilating all instructions and materials that I receive.
- B. Comply** with all directions from Turtle Island instructors or employees.
- C. Act** with awareness that I have bound myself as set out above.

## PHOTO RELEASE (optional):

Please initial here   to indicate your full consent for release of the participant's image to be used by Turtle Island for web/photo archive and promotional materials.

**WARNING:** Under North Carolina law, a farm animal activity sponsor or farm animal professional is not liable for an injury to or the death of a participant in farm animal activities resulting exclusively from the inherent risks of farm animal activities. Chapter 99E of the North Carolina General Statutes.

**WARNING:** Under North Carolina law, there is no liability for an injury to or death of a participant in an agritourism activity conducted at this agritourism location if such injury or death results from the inherent risks of the agritourism activity. Inherent risks of agritourism activities include, among others, risks of injury inherent to land, equipment, and animals, as well as the potential for you to act in a negligent manner that may contribute to your injury or death. You are assuming the risk of participating in this agritourism activity."

I have read and **understand** this document and agree that it will bind me, and any of my representatives, including those set out above. **Legibly Printed Name** of participants: \_\_\_\_\_

Signature of participant if 18 or older: \_\_\_\_\_ Date: \_\_\_\_\_

*If under 18 years of age parent or legal guardian signature is required:*

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

**Printed** name of legal guardian: \_\_\_\_\_ relationship to participant: \_\_\_\_\_

**Father's Medical Information** - please print clearly or type

**Father's Name** - First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Approx. Weight: \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #(s): \_\_\_\_\_ Email Address: \_\_\_\_\_

**Emergency Contact #1:** Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone - Cell: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

Describe your physical fitness level on a scale from 1-10: \_\_\_\_\_ ( 1 = difficulty w/ basic movement , 10 = athlete)

**Medical History-** if you answered yes to any, please describe occurrences & list medications.

Epilepsy: \_\_\_\_\_ Diabetes: \_\_\_\_\_ Asthma: \_\_\_\_\_ (if you have asthma, please plan on bringing three FULL inhalers)

Heart disease: \_\_\_\_\_ Bee-sting allergy: \_\_\_\_\_ Anaphylactic shock: \_\_\_\_\_ Other allergies: \_\_\_\_\_

Describe what happens when contact is made with allergen (example: rash, hives, anaphylaxis, etc): \_\_\_\_\_

When is the last time participant had an allergic reaction: \_\_\_\_\_

Known allergy to any medications: \_\_\_\_\_

List All Current Medications: \_\_\_\_\_

Date of last tetanus booster: \_\_\_\_\_ **Vegetarian:** Y/ N - Any other **dietary needs**, physical or psychological problems, which might affect the safety of yourself or other members of the group, or other information necessary for my care & treatment: \_\_\_\_\_

**Insurance** policy for health, hospitalization or medical care, Name of insurer: \_\_\_\_\_

\_\_\_\_\_ Policy # \_\_\_\_\_ Certificate/Group # \_\_\_\_\_

*I verify that the above information is accurate and complete. In the event of my, or my child or ward's, injury or illness, I give the Turtle Island Preserve staff and the medical staff at the facility to which I or they may be transported permission to render the medical treatment that the providers in their discretion elect to administer.*

Legibly Printed name of all participant(s): \_\_\_\_\_

Signature of participant: \_\_\_\_\_ Date: \_\_\_\_\_

If under 18 years of age signature of parent/ legal guardian required: \_\_\_\_\_

**Printed** name(s) of both: \_\_\_\_\_ / \_\_\_\_\_ Date: \_\_\_\_\_

**Son's Medical Information** - please print clearly or type

**Son's Name** - First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Approx. Weight: \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #(s): \_\_\_\_\_ Email Address: \_\_\_\_\_

**Emergency Contact #1:** Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone - Cell: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

Describe your physical fitness level on a scale from 1-10: \_\_\_\_\_ ( 1 = difficulty w/ basic movement , 10 = athlete)

**Medical History-** if you answered yes to any, please describe occurrences & list medications.

Epilepsy: \_\_\_\_\_ Diabetes: \_\_\_\_\_ Asthma: \_\_\_\_\_ (if you have asthma, please plan on bringing three FULL inhalers)

Heart disease: \_\_\_\_\_ Bee-sting allergy: \_\_\_\_\_ Anaphylactic shock: \_\_\_\_\_ Other allergies: \_\_\_\_\_

Describe what happens when contact is made with allergen (example: rash, hives, anaphylaxis, etc): \_\_\_\_\_

When is the last time participant had an allergic reaction: \_\_\_\_\_

Known allergy to any medications: \_\_\_\_\_

List All Current Medications: \_\_\_\_\_

Date of last tetanus booster: \_\_\_\_\_ **Vegetarian:** Y/ N - Any other **dietary needs**, physical or psychological problems, which might affect the safety of yourself or other members of the group, or other information necessary for my care & treatment: \_\_\_\_\_

**Insurance** policy for health, hospitalization or medical care, Name of insurer: \_\_\_\_\_

\_\_\_\_\_ Policy # \_\_\_\_\_ Certificate/Group # \_\_\_\_\_

*I verify that the above information is accurate and complete. In the event of my, or my child or ward's, injury or illness, I give the Turtle Island Preserve staff and the medical staff at the facility to which I or they may be transported permission to render the medical treatment that the providers in their discretion elect to administer.*

Legibly Printed name of all participant(s): \_\_\_\_\_

Signature of participant: \_\_\_\_\_ Date: \_\_\_\_\_

If under 18 years of age signature of parent/ legal guardian required: \_\_\_\_\_

**Printed** name(s) of both: \_\_\_\_\_ / \_\_\_\_\_ Date: \_\_\_\_\_