January 14th

5:30pm - 10:30pm

SIGNUP DEADLINE
January 12th

Meet at the Fellowship Hall.
Jump On a bus to Pat's Peak.
Go Snow Tubing At Night!

Information
& Form
Packet

$20

SNOW TUBING WARNINGS & RULES

Warnings:

EACH INDIVIDUAL, ACCEPTS THE CONDITIONS OF THE STATE OF NH RSA - A:1 - A:25, THE INHERENT RISKS INVOLVED WITH SNOWTUBING. EACH PARTICIPANT, AS A MATTER OF LAW, MAY NOT MAINTAIN AN ACTION AGAINST THE OPERATOR FOR SUCH INJURIES WHICH MAY RESULT FROM THE INHERENT DANGERS INVOLVED WITH THIS SPORT. THE INDIVIDUAL RECOGNIZES THAT REGARDLESS OF ALL SAFETY MEASURES WHICH MAY BE TAKEN BY THE SKI AREA THE RISK OF INJURY IS PREVALANT.

AMONG OTHER THINGS INJURY MAY BE CAUSED BY:

1. VARYING WEATHER, VARYING TERRAIN AND VARYING SURFACE AND SUBSURFACE SNOW AND ICE CONDITIONS.
2. THE FACT THAT THE TUBE IS NON-DIRECTIONAL.
3. FALLING OFF THE TUBES.
4. COLLISIONS WITH OBJECTS, OTHER TUBES OR INDIVIDUALS.
5. RIDING THE LIFT.
6. OTHER NATURAL OBJECTS OR MAN-MADE OBJECTS THAT ARE INCIDENTAL TO THE PROVISION OR MAINTENANCE OF A TUBING FACILITY IN NEW HAMPSHIRE.

THIS LIST IS ONLY A PARTIAL LIST OF INHERENT RISKS:

Rules:

1. OBEY ALL INSTRUCTIONS OF THE AREA OPERATOR.
2. YOU MUST BE 44" TALL AND OVER THE AGE OF 5.
3. ONLY ONE ADULT AT A TIME.
4. YOU MUST LAY DOWN ON YOUR STOMACH ON THE TUBE.
5. NO SKI BOOTS ALLOWED!
6. HELMETS ARE PERMITTED IF RIDING SOLO OR EVERYONE IN THE GROUP HAS ONE.
7. BE SURE THE CHUTE IS CLEAR BEFORE STARTING YOU DESCENT.
8. **DROP & DRAG FEET TOWARD BOTTOM!!!**
   REPEAT OFFENDERS TOUCHING THE FENCE WILL LOSE PRIVILEGES.
9. CLEAR THE CHUTE AS SOON AS YOUR RIDE IS COMPLETE BY GETTING UP AND WALKING OUT OF THE CHUTE AND EXIT AREA AS QUICKLY AS POSSIBLE.

Pats Peak Ski Area
Group Sales Department
PO Box 2448
Henniker, NH 03242
1-888-PATS PEAK X106

EMERGENCY MEDICAL RELEASE FORM

Pats Peak Ski Area

The purpose of this form is to give permission to the Pats Peak Ski Patrol, any responding ambulance service and/or Concord Hospital to provide emergency treatment for your child in the event of an illness or an injury. In the event of a serious injury or illness, every attempt will be made to contact the legal guardian listed below at the phone number listed. Emergency medical treatment however, will not be delayed while trying to make this contact.

(We) (I) Hereby grant permission to ______________________________

(Print name of the ADULT person who is present)

Group/Program Name: ______________________________

to secure Emergency Medical Care as ______________________________

(Print name of minor)

Address: ______________________________

City/State/Zip: ______________________________

may require, for a period from ______________________________

to ______________________________

(Include entire length of program)

In the event of multiple persons being given permission, on first line above, write: (Any person listed below)

Names of person(s) authorized:

____
____
____
____
____
____
____

List any medication(s) the minor taking:

____
____
____

Lift any allergies:

____
____
____

I have read and understand the information on the emergency medical form. All the information I have provided is true and complete.

______________________________ ______________________________

Signature of parent or legal guardian *Print name and relationship*

Home Phone: ______________________________ Work Phone: ______________________________

Cell Phone: ______________________________ Other: ______________________________

LEARN TO SKI AND RIDE PROGRAM/GROUP COORDINATOR:
KEEP THIS FORM WITH YOU IN THE EVENT OF AN EMERGENCY;
BRING THE FORM TO THE SKI PATROL OFFICE.

TBC Student Ministries
Medical Release Form

Valid Until July 1st, 2011

Last Name: ______________________________ First Name: ______________________________

☐ Male ☐Female Address: ____

City: ______________________________ State:__________ Zip: ______________________

Phone: ___________________________ Cell Phone:_________________________________

Age: ________________ Birthday: ____

Parent's Email: ____

Student's Email: ____

School Attending: ____________________________________ Year in School: ______________

Medical Insurance Company:____

Policy Number: ____

Mother's Name:_____________________________ Cell Phone: _______________________

Company of Employment: _________________________ Work Phone: ___________________

Father's Name:_____________________________ Cell Phone: _______________________

Company of Employment: _________________________ Work Phone: ___________________

Emergency Contact: __________________________ Cell Phone: _______________________

Company of Employment: _________________________ Work Phone: ___________________

Physician: ______________________________ Office Phone : ______________________________

Dentist: ______________________________ Office Phone : ______________________________

Medical History

If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability, or condition to which your child is subject and of which the staff should be aware, and what, if any action of protection is required on account thereof. Submit this notification in writing and attach it to this form. Include names of medications and dosages that must be taken.

Check the following areas of concern for this student. If necessary, add another page with details:

1. For your child's safety and our knowledge, is your student a—

❑ Good Swimmer ❑ Fair Swimmer ❑ Non-Swimmer

2. Does your child have allergies to—

❑ Pollens

❑ Medications ______________________________

❑ Food ______________________________

❑ Insect bites

❑ Other ______________________________

3. Does your child suffer from, or has ever experienced, or is being treated currently for any of the following:

❑ Asthma ❑ Epilepsy / seizure disorder ❑ Heart trouble ❑ Diabetes

❑ Frequently upset stomach ❑ Physical handicap ❑ Other ______________________________

4. Date of last tetanus shot: ______________________________

5. Does your child wear ❑ Glasses ❑ Contact lenses

6. Please list and explain any major illnesses the child experienced during the last year:

Additional comments: ______________________________

____

____

Should this child's activities be restricted for any reason? Please explain:

____

____

For your information, we expect each student to conform to these rules of conduct

- No possession or use of alcohol, drugs, or tobacco
- No students can drive
- No fighting, weapons, fireworks, lighters, or explosives
- No offensive or immodest clothing
- No boys in girls' sleeping quarters and no girls in boys' sleeping quarters
- Participation with the group is expected
- Respect property, respect one another, staff, and adult leaders
- Respect and comply with event schedules

Students who fail to comply with these expectations may be sent home at their parents' expense.

ACTIVITY PERMISSION AND MEDICAL RELEASE

Activities may include, but are not limited to: cookouts, boating, water skiing, swimming, basketball, rollerskating, rollerblading, games in the park, soccer, broomball, ice skating, volleyball, softball, baseball, camping, downhill skiing, snowboarding, hiking, biking, concerts, Bible studies, golfing, miniature golf, hayrides. *Note: If you desire to limit your child's participation in any event, please submit your wishes in writing to the church youth pastor prior to that event.*

____ has my permission to attend all youth activities
NAME OF STUDENT

sponsored by ________Trinity Baptist Church________ hereinafter. (the "Church")
NAME OF ORGANIZATION

from June 2010 to July 1, 2011
DATE DATE

This consent form gives permission to seek whatever medical attention is deemed necessary, and releases the Church and its staff of any liability against personal losses of named child.

I/We the undersigned have legal custody of the student named above, a minor, and have given our consent for him/her to attend events being organized by the Church. I/We understand that there are inherent risks involved in any ministry or athletic event, and I/we hereby release the Church, its pastors, employees, agents, and volunteer workers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of my/our child's involvement. In the event that he/she is injured and requires the attention of a doctor, I/we consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is required from a physician and/or hospital personnel designated by the Church, I/we agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. I/We also acknowledge that we will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider. Further, I/we affirm that the health insurance information provided above is accurate at this date and will, to the best of my/our knowledge, still be in force for the student named above. I/we also agree to bring my/our child home at my/our own expense should they become ill or if deemed necessary by the student ministries staff member.

Parent/guardian signature: ____ Date: _________________