SECTION 3

Please complete ALL sections (i.e. sign every box). Selection will be made on the basis of COMPLETED forms.

a.

CONSENT FOR MEDICAL RELEASE AND EMERGENCY TREATMENT

I understand that in case of a medical or surgical emergency, every responsible effort will be made to contact me for permission for treatment. In the event that I cannot be reached, I hereby give my permission to the adults in charge of the Teen Adventure to secure treatment and to authorize hospitalization, injections, anesthesia or surgery as necessary for his/her emergency care. I understand the expenses for such emergency treatment remain my responsibility.

SIGNATURE _____ DATE _____
Parent / Legal Guardian (circle one)

b.

PUBLICITY RELEASE FORM

I authorize the taking of photos, interviews or videos of my son/daughter during related social and recreational activities during the Teen Adventure.

TEEN'S NAME _____

SIGNATURE _____ DATE _____
Parent / Guardian

SIGNATURE _____ DATE _____
Teen

c.

TEEN CONSENT FORM

1. I will obey the code of conduct for the Teen Adventure—as outlined at the beginning of the retreat.
2. I will not leave the company of the group without the permission and/or presence of a staff member.
3. I will NOT consume intoxicating liquor or non-medicinal drugs.
4. I will respect other's rights to sleep and to enjoy themselves.
5. I know that if I break the rules I will be asked to attend a meeting with the staff and can be sent home.

I have read and understood the rules and agree to abide by them.

SIGNATURE _____ DATE _____
Teen

Attach Photo

TEEN ADVENTURE
CONFIDENTIAL MEDICAL FORM

Please note:

All items in each section must be completed. Mark N/A if any item is not applicable to you.

Please sign all areas of this document

A Telephone follow up call will be required to review the medical form.

PART I General Information (To be completed by applicant or guardian)

Your place on a Teen Adventure is confirmed when we receive all required forms, filled out and signed. The following information is held in complete confidence and is of critical importance. We will email your oncologist to confirm you are medically well to attend the Teen Adventure Trip. If we think that you should not participate in a Teen Adventure Trip at this time, we will contact you.

Name_____ Trip Applied For_____

Address_____ Trip start date_____

City/Province/Postal Code_____

Home Phone_____Cell Phone_____Business Phone_____

Birth Date_____ Age at time of trip_____Gender_____

In case of emergency contact_____Relationship_____

Home Phone_____Cell Phone_____Business Phone_____

Address_____

City/Province/Postal Code_____

Oncologist/Hematologist_____

Family Physician_____Physician Phone_____

I hereby authorize the above stated Physician to release complete information for the medical, social service, and/or psychological record of the above named patient to the Oncology/Hematology/BMT program at BCCH. We only call if required on the trip.

_____ _____

Applicant Signature Date

_____ _____

Parent/Guardian Signature Date

CONFIDENTIAL MEDICAL FORM

For insurance purposes, answers to the following questions are required. We recommend that all Teen Adventure participants be covered by their own medical insurance. If medical care for injury, pre-existing condition or any other reason is required during a Teen Adventure, the participant's health insurance will be primary.

***BC Medical Number**_____

1. Is applicant covered by any other medical care policy? Yes No

2. Name/Address of Insurance Company (if applicable)_____

3. Policy number? (if applicable)_____

4. Does the policy require pre-authorization? (if applicable) Yes No

If yes, please give phone# ( )_____

Signature Required:

Consent is hereby given for the applicant to attend a Teen Adventure Trip. The applicant or guardian further acknowledges that all information provided is accurate and agrees to notify the BC Children's Hospital Division of Pediatric Oncology/Hematology/BMT should there be any change in the health status of the applicant, or information provided.

_____ _____

Applicant Signature Date

_____ _____

Parent/Guardian Signature Date

PART II Applicant Medical History

To be completed by applicant. Fill in every blank. Use additional pages, if necessary.

A. Personal History

Height_____ Weight_____

1. Do you use alcohol?_____ If yes, how much?_____

2. Do you use tobacco?_____ If yes, how much?_____

3. Have been in counseling with a psychologist, psychiatrist, or other psychotherapist within the last year?

Yes No

4. Are you currently in treatment? Yes No

5. Reason for treatment_____

6.. Therapist information

Name_____

Address_____

City/Province/Postal Code_____ Phone ( )_____

CONFIDENTIAL MEDICAL FORM

B. Conditions and symptoms-Do you or have you had any of the following?

Check yes or no for each item

	Yes	No		Yes	No
1. High blood pressure			25. Communicable disease		
2. Heart disease			26. Head injury		
3. Heart murmur			27. Heatstroke		
4. Family history of heart attack			28. Bladder infection		
5. Irregular heartbeat			29. Difficulty urinating		
6. Tuberculosis			30. Kidney problems		
7. Recent exposure to active TB			31. Thyroid problems		
8. Positive TB skin test			32. Endocrine problems		
9. Active hepatitis			33. Hearing impairment		
10. History of hepatitis			34. Vision impairment		
11. Bleeding disorder			35. Motion sickness		
12. Asthma			36. Sleep walking		
13. Diabetes			37. Broken bones		
14. Hypoglycemia			38. Neck problems		
15. Anorexia nervosa			39. Back problems		
16. Bulimia			40. Arm or shoulder problems		
17. Cancer			41. Leg, knee, or ankle problems		
18. Skin problems			42. Foot problems		
19. Frostbite			43. Currently pregnant		
20. Circulation problems			44. Special diet		
21. Active bedwetting			45. Learning disabilities		
22. Headaches			46. Anemia, sickle cell trait, or other blood condition		
23. Stomach ulcers			47. Medical equipment devices		
24. Intestinal problems			48. Other		

Do you currently or regularly have any of the following symptoms?

	Yes	No		Yes	No
49. Chest pain/pressure			56. Heartburn		
50. Heart palpitations			57. Muscle cramps		
51. Unexplained sweating			58. Intolerance of cold temperatures		
52. Frequent shortness of breath			59. Intolerance of warm temperatures		
53. Frequent dizziness			60. PMS or menstrual problems		
54. Frequent fainting					

If you answered “yes” to any of the above items, please explain below. Include the following information.

What specific symptoms are occurring?
How you care for the symptoms or condition?
How symptoms or condition restricts your activity?
How often symptoms occur?
How long symptoms last?
Date of last occurrence?

Item#	Detailed description (please include any important information. (Use Extra pages as necessary)

CONFIDENTIAL MEDICAL FORM

C. Seizure Specific Information

Have you been diagnosed as having a seizure disorder? Yes No

If yes, what is the specific type of seizure?_____

Seizure frequency_____ Current status (active or controlled)_____

Describe your seizure. Do you have any warning? What is the after effect of the seizure?

_____

_____

Describe specific care required in the event of a seizure and recovery time?

_____

_____

_____

D. Medications

Please list any medications that you are currently taking, include over the counter medications. If you will be receiving medication during the adventure, please bring double amounts in the original containers. Please indicate if medication requires refrigeration.

Medication	Dosage	Condition	Side Effects

E. Allergies

List all allergies, including any to medications.

Allergy	Reaction	Medication Required

F. Immunizations

Immunizations	Requirement	Date of last immunization
Tetanus	With 10 years of adventure start date	

The British Columbia's Children's Hospital Division of Pediatric Oncology/Hematology/BMT in regards to the Teen Adventures reserves the right to require an exam by a qualified medical practitioner for any TA trip.

CONFIDENTIAL MEDICAL FORM

BCCH Oncology/Hematology/BMT Program medical staff (for safety) will store all prescription medication of the participants at Teen Adventures. Teen will be required to go to the medical staff to get their medication(s). However, we recognize that some participants may ask for help with tasks such as counting, injections and prompting. The staff will assist to the best of their ability. We will assist with routine oral medications and will not alter (break pill in half) Staff will not coerce a teen to take their medication.

Please answer the following question: (please circle the appropriate answer)

1. Does the participant normally control the supply of his/her medication?	Yes	No
2. Does the participant normally self-medicate?	Yes	No
3. What type of assistance will the participant need to their medication?		
• Will the participant willingly take all the prescribed medications?	Yes	No
• Will BCCH staff need to prompt participant to take medication?	Yes	No
• Will BCCH staff need to help count medication:	Yes	No
• Does the participant experience any side effects from their medication	Yes	No

Is there anything else you would like to share medically about your Teen.

_____

_____

_____

I_____, the parent/guardian of participant_____
give permission for BCCH staff to dispense the medications above during the _____
Teen Adventure.

_____ _____

Parent/Guardian Signature Date

Oncology / Hematology / Bone Marrow Transplant Program

Suzanne Dunbar, Patient/Parent Advocate
T8-505 - 4480 Oak Street, Vancouver, BC, V6H 3V4
Phone: 604-875-2345 ext. 6477
Email: sdunbar@cw.bc.ca

The Oncology/Hematology/BMT Program/The Balding for Dollars Committee/PTB are pleased to announce a "Teen Adventure – Whistler Zipline Trip" (July 22-25,2025). This trip will be facilitated by the professional organization - Power to Be. BCCH Oncology/Hematology/BMT staff will also participate.

PLEASE NOTE:
Please consult your physician if you have any questions regarding your child's participation in the physical aspects of this event.

DISCLAIMER

I understand that British Columbia's Children's Hospital (BCCH) is not responsible for any losses or damages suffered by myself or my child arising from or related to the 'Teen Adventure – Whistler, Zipline" (July 22-25, 2025) for any reason whatsoever, including negligence on the part of BCCH, its servants, or agents.

RELEASE

I understand that there are potential risks associated with my/my child's participation in the 'Teen Adventure - Whistler Zipline Trip" (July 22-25, 2025) activities described above. I understand that participation in these activities may expose me/my child to potential risks including but not limited to physical injury, loss of life, and damage to/loss of property.

I agree, in consideration of C&W permitting me/my child to participate in the 'Teen Adventure – Whistler Zipline Trip" (July 22-25, 2025) to assume all risks involved in participation. I agree that BCCH its officers, directors, employees, servants or agents shall be relieved of all liability for losses and damages of all and every description arising from or related to participation in the "Teen Adventure – Whistler Zipline Trip" (July 22-25, 2025). I further agree to indemnify BCCH for any losses or damages which it may become liable to pay as a result of injury to any person or property damage arising from or related to me or my child's participation in "Teen Adventure – Whistler Zipline Trip" (July 22-25, 2025).

I acknowledge that I am 19 years of age or older, that I have read and agree with the above release and that I accept the above disclaimer as evidenced by my signature.

SIGNATURES

WITNESS:

_____
NAME (PRINT)

_____
SIGNATURE

_____
DATE SIGNED

PARTICIPANT:

_____
CHILD'S NAME (PRINT)

_____
ADULT'S NAME (PRINT)

_____
ADULT'S SIGNATURE

_____
RELATIONSHIP TO CHILD

CONSENT & RELEASE FOR FILMING & PHOTOGRAPHY

DATE _____

I, _____, give BC Children's Hospital Foundation (BCCHF) permission to record my child's image, voice, comments and any other personal information that I provide through digital/still photographs, interviews, sound recordings and/or video recordings during (exact recording session/program to be detailed) _____ on _____ (date). I also acknowledge that it is my choice to participate in these recordings and that I can decline to do so.

I consent to the direct and/or indirect collection, use and disclosure by BCCHF and others of any the personal information contained in or associated with the recordings for informational, educational, research, editorial, media relations or public promotion purposes—through platforms such as radio, print or internet. I also give permission to have my personal information stored by BCCHF and used to contact me for future promotional and fundraising purposes.

I acknowledge that the copyright in the recordings and all other rights in the recordings, copies or reproductions are the sole property of BCCHF. I acknowledge that I will not receive any compensation for these recordings. Finally, I understand that my consent does not expire and the raw, unedited recordings may be kept for an unlimited time.

I hereby release BCCHF from any and all liability arising from use of the recordings as set out above, including without limitation use in conjunction with any media activity, broadcast or other publication for any purpose.

By signing below, I confirm that I have read, understood and agree to the terms and conditions of this consent and release form.

If the subject of the recordings is under the age of 18, this consent must be signed by the minor's parent or guardian on their behalf.

_____ PRINT NAME OF PARENT / GUARDIAN

_____ PRINT NAME OF PATIENT / CHILD

_____ SIGN NAME OF PARENT / GUARDIAN

_____ SIGN NAME OF PATIENT/CHILD (IF OVER 18 YEARS OLD)

CHILD'S DATE OF BIRTH *(MM / DD / YYYY)* _____ / _____ / _____

PHONE NUMBER _____ EMAIL _____

MAILING ADDRESS _____

CITY _____ POSTAL CODE _____

HOSPITAL AREA(S) OF CARE _____

☐ Yes, I am interested in sharing our hospital experience through marketing materials (photos, videos and social media).

☐ Yes, I would be interested in receiving emails regarding opportunities to get involved with the Foundation.

POWER TO BE ADVENTURE THERAPY SOCIETY
INFORMED CONSENT AND ACKNOWLEDGEMENT OF RISK

To be completed by all who are participating in Power To Be Programs

PARTICIPANT'S NAME: _____

PLEASE READ CAREFULLY!

This *Informed Consent and Acknowledgment of Risk* form is an agreement between the participant and/or the custodial parent/guardian of the participant named above and **Power To Be Adventure Therapy Society** (PTB). The intent of this form is to inform you of the inherent risks associated with the activities and environments we operate in and the expectations of our programs so that the choice to participate in any PTB program is made freely with understanding of the associated benefits, risks and personal responsibilities. If you are signing on behalf of someone else (i.e. minor or other participant), please discuss this and have them initial and sign with you to show that they choose to participate.

This is not a waiver and signing this form DOES NOT waive any legal rights.

BENEFITS & RISKS

The activities offered at PTB are designed to pose appropriate challenges for participants. The enjoyment and benefit derived from the activities, events and services provided, and/or organized by PTB is, in part, a result of risks inherent in the activities and locations we program in.

I/WE AGREE
(please initial)

_____ _____
Parent/guardian Participant

- While PTB strives to manage risk, it is neither possible nor desirable to eliminate all risk.
- The potential benefits of participation include access to outdoor recreation, community contribution, community engagement, environmental education and stewardship, family connectedness, development of interpersonal skills, leadership and mentorship, life skills and personal development, and a greater sense of physical health and well-being. PTB offers outdoor and indoor activities which include, but are not limited to: lake, river and ocean canoeing, kayaking and stand up paddle boarding, high and low ropes courses, rock climbing, walking, running, coastal and alpine hiking, caving, swimming, surfing, alpine and Nordic skiing, playing games, yoga, cycling, snowshoeing, gardening, animal interactions, and front country and back country camping.
- PTB offers opportunities to learn or be a part of experiences that include, but are not limited to: use of camp stoves and campfires, cutting tools (i.e. knives, saws and hatchets), education of wilderness skills, transportation, consumption of food and beverage, consumption and storage of water, rescue and first aid services, equipment and adaptive modifications, and accommodation.
- The activities include inherent risks that may be different or greater than those risks normally assumed at home, work or school. These risks include, but are not limited to: burns or lacerations associated with cooking, exposure to potential environmental and food allergens, lifting, carrying heavy objects, exposure to inclement weather, slipping, falling, insect or animal bites that may or may not be a carrier of disease, being struck by falling objects, immersion in cold water, hypothermia (cold exposure), hyperthermia (heat exposure), uneven terrain, stream crossings, travel on active logging and unregulated roads, social or economic losses, improper use or malfunction of equipment or adaptive modifications, loss or damage of personal property, infectious disease contracted through viruses, bacteria, parasites, and fungi which may be transmitted through direct or indirect contact, injury, fatigue, permanent disability, illness or fatality.
- Communication and emergency response times will vary depending on the access to resources, activity location, remoteness, time of year, weather and time of day.

I/WE AGREE
(please initial)

_____ _____
Parent/guardian Participant

AGREEMENT

I/we understand and agree that participation in PTB activities require participants to, at times:

- Use third party service and facility partners.
- Share the responsibility for the safety of their self and others during all activities.
- Disclose any personal circumstances which include, but are not limited to, medicinal practices that may impair judgment or physical awareness or ability to participate in program.
- Follow all instructions and directions of PTB staff/volunteers and that failure to do so may compromise safety and result in removal from the program.

By signing this I/we agree to:

- Acknowledge the above risks and accept responsibility for all damages, loss and benefits resulting from participation.
- Contact PTB in advance if I/we have any questions about the risks described above or pertaining to any other aspects of the program.

This Agreement will be governed and interpreted in accordance with the laws of the Province of British Columbia.

PTB respects the privacy of participants and will not identify individuals if using photographs or other images for educational, promotional, memory sharing, or other purposes unless permission has been granted verbally and in writing.

This *Informed Consent and Acknowledgment of Risk* agreement stands to be valid for the length of your involvement with Power To Be Adventure Therapy Society (PTB).

PARTICIPANT

_____	_____	_____
Participant's printed name	Participant's signature	DATE (D/M/Y)

PARENT/LEGAL GUARDIAN

_____	_____	_____
Custodial parent/ legal guardian's printed name	Custodial parent/ legal guardian's signature	DATE (D/M/Y)

Additional Family Members participating:

_____	_____	_____
Participant's printed name	Participant's signature	DATE (D/M/Y)
_____	_____	_____
Participant's printed name	Participant's signature	DATE (D/M/Y)
_____	_____	_____
Participant's printed name	Participant's signature	DATE (D/M/Y)
_____	_____	_____
Participant's printed name	Participant's signature	DATE (D/M/Y)

PARENT/LEGAL GUARDIAN for above family members under the age of 19.

_____	_____	_____
Custodial parent/ legal guardian's printed name	Custodial parent/ legal guardian's signature	DATE (D/M/Y)

WITNESS

_____	_____	_____
Witness printed name	Witness signature	DATE (D/M/Y)