OFFICE USE ONLY:
Registration # __________
Amt. Encl. $_____ Check # ______

KAYAK FISHING WEEKEND
Registration Form
September 24, 25, 26, 2010

Only one person may register per form. Please photocopy for additional registrations.

PLEASE PRINT LEGIBLY

Name: ____

Address: ____

City: ________________________ State: __________ Zip: ___________

Phone: Work: ______________ Home: __________________

E-mail: ____

The applicant, by signing below, recognizes that the program involves some risk and that she/he takes responsibility for all actions or injury that may result by participating. I understand that photographs and/or filming may occur during the sessions and may be used in future support of the program.

Applicant signature: ______________________________________

FEE: $275. Includes instruction, program materials, use of demonstration equipment, Friday evening reception, all meals on Saturday, breakfast and lunch on Sunday and lodging. FEE DUE WITH REGISTRATION, SPACE IS LIMITED TO 15, RESERVE YOUR SPOT EARLY!

PLEASE INDICATE METHOD OF PAYMENT:

Check – Total Amount: $__________ Payable to: NH Wildlife Trust

Visa MasterCard Exp. Date: ___/_____ Signature: ______________________

Credit Card # _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Total Credit Card Amount: $_______

I would like to donate to the NH BOW Scholarship Fund: $25.00 $50.00 other $__________

REMIT PAYMENT ALONG WITH REGISTRATION FORM AND MAIL TO:

BOW c/o N.H. Fish and Game Dept.
11 Hazen Drive
Concord, NH 03301
Attn: Tina Davenport

NO REGISTRATIONS WILL BE ACCEPTED BY TELEPHONE, FAX OR E-MAIL.

Sponsored by
New Hampshire Fish and Game Department and
New Hampshire Wildlife Federation
www.nhbow.com

REGISTRATION #__________

BECOMING AN OUTDOORS~WOMAN
Medical History Questionnaire
All Information is Confidential

Name____ Date of Birth______________________________

Physician____ Phone #__________________________________

Emergency Contact Name_______________________________ Phone#___________________________________

QUESTIONS:

Please check any of the following medical conditions that apply to you:

Yes No Are you allergic to any medication (aspirin, penicillin, etc.)? List______________________________

Yes No Do you take any medication critical to your health? List______________________________

Yes No Have you ever been told by a doctor that you have epilepsy? When______________________________

Yes No Have you had recent surgical operations, accidents or injuries?

When/What?_____________________________

Yes No Have you been "knocked out" unconscious, had a concussion or head injury? When?____________________

Yes No Are you pregnant?____

Do you wear: glasses? or contact lenses?

Date of last tetanus immunization:____

Please check any of the following medical conditions you have had within the last five years:

Hay fever or allergies. (Especially to bees, ants, etc.) If yes, please list ______________________________
If yes, bring your own Epi~Pen. We don't provide them.

Heart Disease
Asthma
Diabetes
Seizures
Fainting spells
High blood pressure

Do you have any medical training?

Doctor Nurse Emergency Medical Technician Other____________________________

Is there anything else about your health you would like us to know in case of an emergency? _______________

____

____

Signature____ Date____________________________________

PLEASE RETURN THIS QUESTIONNAIRE WITH YOUR REGISTRATION FORM.

Revised 03-11-10