



*Adventure Learning Experiences Inc.*

*"Where Service and Leadership come together"*

60 Southgate Crescent, Richmond Hill, ON L4B 2E5 TICO#: 50021706

Ph: 905-731-8183 E-Mail: [info@adventurelearningexperiences.com](mailto:info@adventurelearningexperiences.com)

Website: [www.adventurelearningexperiences.com](http://www.adventurelearningexperiences.com)

## **Tanzania Study and Leadership Program July 31 – August 19, 2016**

### **Forms Package**

Please complete and sign all forms and submit no later than July 15, 2016

Adventure Learning Experiences Inc.

Attention: Jen Wilson

41 Kimbourne Ave.

Toronto, ON

M4J 4J1

or e-mail to [info@adventurelearningexperiences.com](mailto:info@adventurelearningexperiences.com)

**NOTE:** If you do not have your medical travel insurance purchased by the above deadline, please submit the remainder of the forms by the deadline and send in your medical travel insurance information as soon as you receive it.



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## Tanzania Study and Leadership Program 2016 Acknowledgement and Agreement

Name (Please Print) \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_

Email: \_\_\_\_\_

I, my heirs and executors, absolve absolutely and release Adventure Learning Experiences Inc., their officers, directors, employees and agents from any responsibility for any injury-personal or material, loss, or any liability whatsoever that I might suffer from my participation in any portion of the Tanzania Study and Leadership Program 2016, from July 31, 2016 to August 19, 2016 inclusive, including but not limited to transportation, events, and programs in connection with the same.

I have carefully read the foregoing and by my signature done at

\_\_\_\_\_ (city) this \_\_\_\_\_ day of \_\_\_\_\_ (month), 20\_\_\_\_,

I agree to be bound by its contents.

Signature: \_\_\_\_\_



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## **Tanzania Study and Leadership Program 2016 Consent to Medical Attention and Treatment Form**

In case of emergency, I hereby consent, where it is impractical to communicate with me, to arrange for me to receive such medical treatment or surgical treatment procedures deemed by a qualified medical practitioner to be necessary for my health and welfare, including the administration of an anesthetic and the performance of any operation during the period July 31, 2016 to August 19, 2016 inclusive.

I also undertake to pay all costs, which may be incurred for my medical attention, ambulance transportation, and drugs.

**Full Name** (Please Print) \_\_\_\_\_

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_



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## Emergency Contacts

Full Name \_\_\_\_\_

### Emergency Contacts:

Name \_\_\_\_\_

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Relationship \_\_\_\_\_

Phone \_\_\_\_\_

Phone \_\_\_\_\_

Email \_\_\_\_\_

Email \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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## Travel Health Information

This is intended to assist a qualified medical practitioner, in case of emergency, in effectively serving your health needs. All information will be held in strict confidence and will only be shared between the leaders and attending health care officials.

**Note:** Please bring your **Immunization Record** with you on the trip.

Full Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Health Card Number \_\_\_\_\_

Family Doctor \_\_\_\_\_

Phone number \_\_\_\_\_

Email \_\_\_\_\_

a) Do you have any health conditions that you feel are important for the leaders to know?

b) Are you currently on any medications that you feel are important for the leaders to know?

c) Is there any other information, which you feel would be important for the leaders to know relative to your personal health needs?

d) Are there any dietary restrictions that you would like us to be aware of?



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## **Medical/Travel Insurance Policy**

**Name** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_

**Company** \_\_\_\_\_

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

**Contact Information from Canada** \_\_\_\_\_



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## CODE OF BEHAVIOUR

An international program demands self-discipline, understanding, and maturity. Acceptance of the following standards of behaviour will help provide the best possible learning experience for all participants. Disregard for these standards may undermine the program and could result in the dismissal of the student from the program and the loss of any potential course credit.

### I COMMIT

1. To participate in all the organized activities of the program.
2. To respect the customs and culture of the host countries.
3. To fully respect and co-operate with the other participants in the group.
4. To function at all times within the laws of Canada and the host countries.

### I WILL REFRAIN FROM

1. Driving any motor vehicle.
2. Hitch-hiking
3. Forming an exclusive relationship with another group member during the program.
4. Entering the sleeping area of a member of the opposite sex unless it has been designated as a meeting room by the teacher-in-charge.

### THE FOUR COMMANDMENTS

1. No smoking.
2. No use of alcohol.
3. No use or possession of illegal drugs.
4. No sexual harassment, including public displays of affection.

I commit myself to abide by the above standards of behaviour. I understand that not abiding by these standards could result in my dismissal from the program. Any extra costs incurred in arranging my safe passage home will be paid for by my family.

Student's Signature: \_\_\_\_\_

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

Parent's Signature: \_\_\_\_\_

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



# TORONTO CATHOLIC DISTRICT SCHOOL BOARD

## Parent/Guardian Informed Consent Form

### For International Excursions

International field trips may present various elements of risks, as might various forms of related transportation including air flight. Accidents related to such activities may occur and cause injury to a student or students through no fault of the school board, a transporter or of a facility at which activities take place.

PARTICIPANTS MUST ASSUME THESE RISKS.

**THE TORONTO CATHOLIC DISTRICT SCHOOL BOARD DOES NOT PROVIDE ANY ACCIDENTAL DEATH, DISABILITY, DISMEMBERMENT OR MEDICAL EXPENSES INSURANCE ON BEHALF OF STUDENTS PARTICIPATING IN FIELD TRIPS.**

ACKNOWLEDGEMENT

WE HAVE READ AND UNDERSTOOD THESE WARNINGS:

Dated: \_\_\_\_\_

\_\_\_\_\_  
(Signature of Student)

\_\_\_\_\_  
(Signature of Parent/Guardian)

I GIVE \_\_\_\_\_ permission to participate in  
(Name of Student)

the excursion sponsored by:

\_\_\_\_\_  
(School)

to \_\_\_\_\_  
(Destination(s))

**during** \_\_\_\_\_ **TO:** \_\_\_\_\_  
(Date of trip, inclusive)

Dated: \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_

(September 2013)







# TORONTO CATHOLIC DISTRICT SCHOOL BOARD CONSENT TO MEDICAL TREATMENT

(a) When on Field Trips

and (b) When parents cannot be contacted

*The information on this form is collected under the authority of the Education Act, R.S.O. 1991, Section 170(1) and will be used for administration of school excursions and in the event of a medical emergency. If you have any questions regarding the collection or use of this information, please contact the school Principal.*

**To: Any Qualified Health Care Provider**

## CONSENT TO MEDICAL TREATMENT

I hereby consent to the administration of any medical treatment deemed by any qualified medical practitioner to be necessary for the health and welfare of my child, \_\_\_\_\_

Child's Name

including the administration of an anaesthetic and the performance of any necessary operation during the period \_\_\_\_\_ to

Y – M – D

\_\_\_\_\_  
Y – M – D

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_

Health Card Number: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Guardian  
(Signature of student if over 18 years of age)

\_\_\_\_\_  
Date

**TORONTO CATHOLIC DISTRICT SCHOOL BOARD  
MEDIA CONSENT FORM**

I, \_\_\_\_\_, hereby give my consent to  
(Name of Parent/Guardian)

Centro Scuola & The Toronto Catholic District School Board for my child,  
\_\_\_\_\_, of \_\_\_\_\_,  
(Name of Student) (Name of School)

to participate in the media activity in: \_\_\_\_\_  
(Date)

in \_\_\_\_\_, and to be filmed,  
(Location)

audiotaped, videotaped or photographed by print or broadcast media.

I also consent to my child being interviewed for the purpose of broadcast or printing by the news media on the following topics:

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\_\_\_\_\_  
(Signature of Parent/Guardian)

\_\_\_\_\_  
(Date)



*This personal information is collected under the authority of the Education Act and is used for the purpose of promoting Catholic education in Toronto.*



# TORONTO CATHOLIC DISTRICT SCHOOL BOARD STUDENT'S HEALTH AND SAFETY INFORMATION FORM

*The information on this form is collected under the authority of the Education Act, R.S.O. 1991, Section 170(1) and will be used for administration of school excursions and in the event of a medical emergency. If you have any questions regarding the collection or use of this information, please contact the school Principal.*

School Name: \_\_\_\_\_

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_  
Last Name First Name Y- M- D M or F

Student's Home Address: \_\_\_\_\_  
Number Street City Postal Code

Student's Home Phone Number: \_\_\_\_\_

Father's (Guardian's) Name: \_\_\_\_\_

Father's (Guardian's) Address: \_\_\_\_\_  
(If different from student's)

Place of Employment: \_\_\_\_\_ Phone: \_\_\_\_\_

Mother's (Guardian's) Name: \_\_\_\_\_

Mother's (Guardian's) Address: \_\_\_\_\_  
(If different from student's)

Place of Employment: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Alternate: \_\_\_\_\_ Phone: \_\_\_\_\_

OHIP Health Card No: \_\_\_\_\_ Blood Type (if known): \_\_\_\_\_

Does your child have any special condition which must or should be taken into consideration in his/her participation in a full academic and physical program?

Allergy: \_\_\_\_\_

Asthma: \_\_\_\_\_

Diabetes: \_\_\_\_\_

Epilepsy: \_\_\_\_\_

Feet or Legs: \_\_\_\_\_

Heart: \_\_\_\_\_

Skin: \_\_\_\_\_

Rheumatic Fever: \_\_\_\_\_



# TORONTO CATHOLIC DISTRICT SCHOOL BOARD STUDENT'S HEALTH AND SAFETY INFORMATION FORM

Recent illness or operation: \_\_\_\_\_

\_\_\_\_\_

Other:

\_\_\_\_\_

\_\_\_\_\_

Does your child carry any medication for the above-mentioned condition(s)? If so, please give details:

\_\_\_\_\_

\_\_\_\_\_

Has he/she any drug allergy or sensitivity? If so, please give details:

\_\_\_\_\_

\_\_\_\_\_

Has he/she any serum sensitivity? If so, please give details:

\_\_\_\_\_

\_\_\_\_\_

Date of last tetanus shot (if known): \_\_\_\_\_

If there are any medical details that you feel might be of some assistance to the teacher to ensure the safety of your child, please contact the teacher at school or use the space below to inform the teacher of these details.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Guardian

(Signature of student if over 18 years of age)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Supervisor-in-charge of Excursion

(Page 2 of 2)

\_\_\_\_\_  
Date