Rites of Passage, Inc. • Program Registration Form

220 Oak Meadow Dr., Suite A • Los Gatos, CA 95032 • (408) 399-5545 • mensgroups.com

I wish to register for the following program:

_____ _____

Program Title Program Dates

NAME of participant: _____

STREET / P.O. BOX: _____

CITY: _____ STATE: _____ ZIP _____

HOME PHONE: ( ) _____ WORK PHONE: ( ) _____

E-MAIL: _____

- Please enclose your **non-refundable** deposit of $300 for Vision Quest programs
- We accept checks and money orders
- Balance is due one month before departure, after which no refunds can be made
- Upon receipt of your registration, we will send you additional preparation materials

Please sign below. If registrant is under age 18, a parent or guardian's signature is also required.

_____ _____

Signature of participant Date

_____ _____

Signature of parent or guardian if required Date

_____ _____

Print name of parent or guardian Phone # if different from registrant's

Please fill out the Confidential Health Questionnaire on the back of this form. To complete registration, mail or fax (our phone line is also the fax number) the completed form, along with a **letter of intent** describing your reasons for participating in this program.

Rites of Passage, Inc.

CONFIDENTIAL HEALTH QUESTIONNAIRE

NAME of participant: _____

AGE: _____ DATE OF BIRTH: _____ SEX: _____ HEIGHT: _____ WT: _____

For each of the following, circle **YES** and explain below if you have any previous injuries, pre-existing conditions, special conditions/needs, or other pertinent medical information (such as a recent surgery). Otherwise, circle **NO**.

Eyes	YES	NO	Lungs	YES	NO	Lower Back	YES	NO	Thighs	YES	NO
Ears	Y	N	Asthma	Y	N	Groin	Y	N	Ankles	Y	N
Head	Y	N	Heart	Y	N	Pelvis	Y	N	Feet	Y	N
Neck	Y	N	Internal Organs	Y	N	Lower Legs	Y	N	Knees	Y	N
Arms	Y	N	Diabetes	Y	N	Blood Pressure	Y	N	Other	Y	N
Wrists	Y	N	Upper Back	Y	N	Do you smoke?	Y	N			
Hands	Y	N	Shoulders	Y	N	Wear contacts?	Y	N			

PLEASE EXPLAIN ANY "YES" ANSWERS HERE:

ANY ALLERGIES? (Food, medicine, bee sting, medications, etc.) Describe: _____

_____

CURRENTLY TAKING MEDICATION? Yes ___ No ___ Name of Medication: _____

For what? _____ Dosage: _____

CURRENTLY UNDER THE CARE OF A PHYSICIAN? Yes ____ No ____ For what? _____

CURRENTLY UNDER THE CARE OF A PSYCHOTHERAPIST? Yes ____ No ____ If yes, explain: _____

_____

EMERGENCY CONTACT: _____ PHONE: (H) _____ (W) _____

MEDICAL INSURANCE CARRIER: _____ POLICY #: _____

DOCTOR'S NAME: _____ PHONE: _____

I have read the above questions and certify that to the best of my knowledge my answers are complete and correct.

SIGNED: _____ DATE: _____

(Registrant, or Parent/Guardian if registrant is under age 18)