



## Application for Admission

APPLICANT NAME \_\_\_\_\_

PLEASE CIRCLE the trek in which you are seeking enrollment:

### ONE-ON-ONE • SUMMER PROGRAM • OPEN ENROLLMENT

Soltreks designs an individualized therapeutic plan called a personal development plan for the applicant based on the information provided within the application. Without accurate information, an honest decision as to whether Soltreks is likely to be an appropriate setting and helpful to the applicant cannot be made. To affect a better opportunity and effective design, please be sure to carefully complete the application with full disclosure and to return to Soltreks as soon as possible.

#### APPLICATION CHECK LIST:

- Complete a screening call with Admissions personnel
- Complete the Application and pay the application fee
- Pay deposit to reserve a space
- Complete a physical examination and send paperwork to Soltreks
- Include a copy of the applicants immunization records
- Copy of applicant's custody agreement if applicable
- Include current photo of applicant
- Lab tests sent
- Prescription Medication Inventory accurate and complete
- All paperwork is required and must arrive prior to applicants enrollment
- Arrange travel for the beginning of the trek
- Signature on all agreements, releases, and forms

PLEASE INCLUDE an Application Fee of \$150.00 with this application.

*Mail completed application to:*

*Soltreks, Inc. 2346 Highway #3, Two Harbors, MN 55616 or*

*Fax completed application to 707-549-3785.*

*Contact Soltreks Inc. at 218-834-4607 with questions.*



Applicant's Full Name: \_\_\_\_\_

## Parent/Guardian Information

### Father

Name (last) \_\_\_\_\_ (first) \_\_\_\_\_ (middle) \_\_\_\_\_

Home Address (street) \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip) \_\_\_\_\_

Social Security Number \_\_\_\_\_ Legal Custody  Yes  No

Business Address (street) \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip) \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Cellular \_\_\_\_\_

Fax Number \_\_\_\_\_ Email Address: \_\_\_\_\_

If father deceased, when: \_\_\_\_\_ Where: \_\_\_\_\_

Step-Father's Full Name (if applicable) \_\_\_\_\_ Phone \_\_\_\_\_

### Mother

Name (last) \_\_\_\_\_ (first) \_\_\_\_\_ (middle) \_\_\_\_\_

Home Address (street) \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip) \_\_\_\_\_

Social Security Number \_\_\_\_\_ Legal Custody  Yes  No

Business Address (street) \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip) \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Cellular \_\_\_\_\_

Fax Number \_\_\_\_\_ Email Address: \_\_\_\_\_

If mother deceased, when: \_\_\_\_\_ Where: \_\_\_\_\_

Step-Mother's Full Name (if applicable) \_\_\_\_\_ Phone \_\_\_\_\_

### Other Legal Guardian

Legal Guardian or Person Placing Child in Care (if other than parent) \_\_\_\_\_ Relationship \_\_\_\_\_

Name (last) \_\_\_\_\_ (first) \_\_\_\_\_ (middle) \_\_\_\_\_

Home Address (street) \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip) \_\_\_\_\_

Social Security Number \_\_\_\_\_ Legal Custody  Yes  No

Business Address (street) \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip) \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Cellular \_\_\_\_\_

Fax Number \_\_\_\_\_ Email Address: \_\_\_\_\_

Applicant's Full Name: \_\_\_\_\_

**Additional Family Information**

**Step-Father**

Name (last) \_\_\_\_\_ (first) \_\_\_\_\_ (middle) \_\_\_\_\_

Home Address (street) \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip) \_\_\_\_\_

Social Security Number \_\_\_\_\_ Legal Custody  Yes  No

Business Address (street) \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip) \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Cellular \_\_\_\_\_

Fax Number \_\_\_\_\_ Email Address: \_\_\_\_\_

If mother deceased, when: \_\_\_\_\_ Where: \_\_\_\_\_

**Step-Mother**

Name (last) \_\_\_\_\_ (first) \_\_\_\_\_ (middle) \_\_\_\_\_

Home Address (street) \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip) \_\_\_\_\_

Social Security Number \_\_\_\_\_ Legal Custody  Yes  No

Business Address (street) \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip) \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Cellular \_\_\_\_\_

Fax Number \_\_\_\_\_ Email Address: \_\_\_\_\_

If mother deceased, when: \_\_\_\_\_ Where: \_\_\_\_\_

**Sibling Information**

List all brothers, sisters, step-brothers and step-sisters of the applicant, noting if they are living in the same residence as the applicant.

First/Last Name	/Age	Male	Female	Biological	Adopted	By Marriage	Same Residence
_____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Applicant's Full Name: \_\_\_\_\_

## Current Professional Relationships

Please list all educational consultants, psychiatrists, psychologist, counselors/therapists, and other professionals who are currently working with the applicant. If there are additional professional whom you would like to communicate, please make an additional copy of this form.

1. Name \_\_\_\_\_ Dates of Service (from) \_\_\_\_\_ (to) \_\_\_\_\_

Address (street) \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip) \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

Nature of Service \_\_\_\_\_

2. Name \_\_\_\_\_ Dates of Service (from) \_\_\_\_\_ (to) \_\_\_\_\_

Address (street) \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip) \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

Nature of Service \_\_\_\_\_

(Please list any additional names on a separate sheet of paper.)

I/We hereby authorize the above professional(s) to release information regarding the above named applicant to Soltreks, Inc. and authorize Soltreks, Inc. to release information regarding the applicant to the professionals indicated above.

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

The information received will be used to evaluate my situation and to plan for and coordinate services for me and my family, or for other purposes as specified. The permission is good for one year, or until:

\_\_\_\_\_

**Please check all that apply for communication with the above parties:**

Send Weekly Updates/Summary     Send Discharge Summary Only     Send no information from Soltreks

### **Out of Home Placement (If Applicable)**

Please list placements outside of the home: boarding schools, foster homes, psychiatric hospitalizations, etc.

Name and Location \_\_\_\_\_

Consulting Professional \_\_\_\_\_ Dates: From \_\_\_\_\_ To \_\_\_\_\_

Reason for Placement and Subsequent Departure \_\_\_\_\_

SOLTREKS is an independent, nondenominational program and does not discriminate against applicants on the basis of race, religion, sex, color, sexual orientation or ethnic origin.

Applicant's Full Name: \_\_\_\_\_

## Parent Assessment of Applicant

The following questions are designed to assist us in working most effectively with the applicant and your family. **FEEL FREE TO CONTINUE YOUR ANSWERS ON ADDITIONAL PAPER.**

1. Describe the applicant's current behavior and significant events leading to your decision to enroll, and how long this has persisted.

2. Describe the applicant's relationship with parents, siblings, peers, and other significant relationships.

Applicant's Full Name: \_\_\_\_\_

3. Describe the positive qualities, interests and accomplishments of the applicant.

4. Describe the applicant's methods for expressing anger, frustration, and disappointment.

5. Name any significant family members or friends who are deceased. Please describe circumstance.

Applicant's Full Name: \_\_\_\_\_

6. Describe each parent's relationship with the applicant.

7. Describe your goal/expectations for the applicant and for your partnership with Soltreks.

8. Has the applicant ever experienced or exhibited any of the following? (If yes, please explain.)

Been held back a grade, expelled or withdrawn from school?  Yes  No Date \_\_\_\_\_

Please explain \_\_\_\_\_

► Eating disorder?  Yes  No Date \_\_\_\_\_

If yes, please explain and list any medical intervention \_\_\_\_\_

**Applicant's Full Name:** \_\_\_\_\_

▶ Arson or fire setting?  Yes  No Date \_\_\_\_\_ Police Intervention?  Yes  No  
Please explain \_\_\_\_\_

▶ Suicide discussion or attempt?  Yes  No Date \_\_\_\_\_  
Medical Intervention Required?  Yes  No  
Please explain \_\_\_\_\_

▶ Cruelty to animals?  Yes  No Date \_\_\_\_\_  
Please explain \_\_\_\_\_

▶ Drug/alcohol/tobacco use?  Yes  No  
(Describe type if known, and frequency: experimental, moderate, heavy)  
Please explain \_\_\_\_\_

▶ Runaway history (How many times and for how long? Considered a RUN RISK?  Yes  No  
Please explain \_\_\_\_\_

▶ Assaultive/aggressive behavior?  Yes  No Date \_\_\_\_\_  
Please explain toward whom: parents, siblings, other adults, peers.  
\_\_\_\_\_

▶ Sexual or physical abuse/rape or witnessed any?  Yes  No  
Please explain \_\_\_\_\_

▶ Sexual activity?  Yes  No Date \_\_\_\_\_  
Please explain \_\_\_\_\_

▶ Self abusive behavior?  Yes  No Date \_\_\_\_\_  
Medical Intervention Required?  Yes  No  
Please explain \_\_\_\_\_

▶ Police intervention?  Yes  No Date \_\_\_\_\_ On probation?  Yes  No  
Date probation ends \_\_\_\_\_  
Please explain \_\_\_\_\_

9. Please list any additional comments regarding the applicant's behavior.

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

10. Has the applicant been diagnosed with learning difficulties?  Yes  No  
Please explain \_\_\_\_\_

11. Has the applicant had any educational, behavioral, or psychological testing?  Yes  No  
Dates: \_\_\_\_\_

Please explain: \_\_\_\_\_

Applicant Full Name: \_\_\_\_\_

## Applicant Self-Assessment and Goals

Please help us in getting to know you in advance by answering the following questions. Your answers will help in designing a trek that will best meet your needs.

1. What do you know about SOLTREKS, and how do you feel about taking part in a trek?
  
2. What kinds of outdoor activities do you like?
  
3. What do you see as being the biggest issue in your family? How have you tried to help solve the problem?
  
4. What do you struggle with the most?
  
5. Describe in 1 word, your Mother \_\_\_\_\_ Father \_\_\_\_\_  
Sibling's \_\_\_\_\_ and yourself \_\_\_\_\_.
  
6. How would your friends describe you?
  
7. Who or what is it that you have the hardest time relating to?
  
8. What do you do that makes others think you would benefit from a Trek?
  
9. What changes would you like to see for yourself and your family?
  
10. What are your plans for school, college, jobs, and other activities?
  
11. What would you like to be asked?

Thank you. We look forward to meeting you.

Applicant's Full Name: \_\_\_\_\_

## Third Party Assessment

Please copy and distribute to at least one adult (not within immediate family) who maintains a significant relationship with the applicant (i.e. therapist, school counselor, adult mentor, etc.).

Your Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

1. How long have you know the applicant and in what capacity?
  
2. Describe your relationship with the applicant.
  
3. Describe the applicant's primary issues and behaviors. How and when did they start?
  
4. Describe applicants relationship with parents, siblings, peers, others.
  
5. Describe the positive qualities and accomplishments of the applicant.
  
6. What positive support systems does the applicant have? (i.e., friends, sports, clubs, teachers, clergy, relatives, etc.) Have you noticed any changes in these support systems in the past 6 months to a year?
  
7. Based upon your understanding of Soltreks, how do you think the program will benefit the applicant?
  
8. Anything else you would like to share that might be useful for planning purposes:

Thank you for taking the time to complete this form.

Applicant's Full Name: \_\_\_\_\_

**Participant Agreement**  
**Including Assumption of Risk, Agreements,**  
**Releases and Addendums**

In consideration of the services of Soltreks, Inc. their agents, owners, officers, volunteers, participants, employees, and all other persons or entities acting in any capacity on their behalf (hereinafter collectively referred to as "Soltreks"), I hereby agree to release, indemnify, and discharge Soltreks, on behalf of myself, my spouse, my children, my parents, my heirs, assigns, personal representative and estate as follows:

1. I acknowledge that outdoor adventure based activities such as camping, hiking, backpacking, rock climbing and canoeing entails known and unanticipated risks that could result in physical or emotional injury, paralysis, death, or damage to myself, to property, or to third parties. I understand that such risks simply cannot be eliminated without jeopardizing the essential qualities of the activity. **The risks include, among other things:** Slipping and falling; falling objects; water hazards; exhaustion; exposure to temperature and weather extremes which could cause hypothermia, hyperthermia (heat related illnesses) heat exhaustion, sunburn, dehydration; and exposure to potentially dangerous wild animals, insect bites, and hazardous plant life; equipment failure; accidental drowning; and improper lifting or carrying. Furthermore, Soltreks instructors/employees have difficult jobs to perform. They seek safety, but they are not infallible. They might be unaware of a participant's fitness or abilities. They might misjudge the weather or other environmental conditions. They may give incomplete warnings or instructions, and the equipment being used might malfunction.
2. I expressly agree and promise to accept and assume all of the risks existing in this activity. My participation in this activity is purely voluntary, and I elect to participate in spite of the risks.
3. I hereby voluntarily release, forever discharge, and agree to indemnify and hold harmless Soltreks from any and all claims, demands, or causes of action, which are in any way connected with my participation in this activity or my use of Soltreks equipment or facilities, **including any such claims which allege negligent acts or omissions of Soltreks.**
4. Should Soltreks or anyone acting on their behalf, be required to incur attorney's fees and costs to enforce this agreement, I agree to indemnify and hold them harmless for all such fees and costs.
5. I certify that I have adequate insurance to cover any injury or damage I may cause or suffer while participating, or else I agree to bear the costs of such injury or damage myself. I further certify that I am willing to assume the risk of any medical or physical condition I may have.
6. In the event that I file a lawsuit against Soltreks, I agree to do solely in the state of Minnesota, and I further agree that the substantive law of Minnesota shall apply in that action without regard to the conflict of law rules of that state. I agree that if any portion of this agreement is found to be void or unenforceable, the remaining portions shall remain in full force and effect.  
**By signing this document, I acknowledge that if anyone is hurt or property is damaged during my participation in this activity, I may be found by a court of law to have waived my right to maintain a lawsuit against Soltreks on the basis of any claim from which I have released them herein. I have had sufficient opportunity to read this entire document. I have read and understood it, and I agree to be bound by its terms.**

Signature of Applicant: \_\_\_\_\_ Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

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

**PARENT'S OR GUARDIAN'S ADDITIONAL INDEMNIFICATION**

(Must be completed for participants under the age of 18)

In consideration of \_\_\_\_\_ (print minor's name) ("Minor") being permitted by Soltreks to participate in its activities and to use its equipment and facilities, I/We further agree to indemnify and hold harmless Soltreks from any and all Claims which are brought by, on behalf of Minor, and which are in any way connected with such use or participation by Minor.

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

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

Print Name(s) \_\_\_\_\_ Date \_\_\_\_\_

**Applicant's Full Name:** \_\_\_\_\_

**Consent, Releases and Agreements**

**TRANSPORTATION**

I/We hereby authorize SOLTREKS, Inc. at its sole discretion to place my child on a public carrier, (i.e., airplane, train or bus) or private automobile for the purpose of transporting him/her to such location as communicated by the undersigned to SOLTREKS, Inc. for all program needs and events (including Canada and Mexico). I/We hereby release and discharge SOLTREKS, Inc. its agents, employees, contractors, officers and directors from all claims, demands, actions, judgments and executions the undersigned may have against SOLTREKS, Inc. for all personal injuries, known or unknown, and injuries to property, personal or real, caused by or arising out of the removal and transportation of my child from SOLTREKS, Inc. as set forth above.

**INITIALS** \_\_\_\_\_

**INITIALS** \_\_\_\_\_

**CONSENT TO EXAMINATION AND TREATMENT**

I/We hereby authorize SOLTREKS, Inc., Directors, or any staff member or contractor of SOLTREKS, Inc. to provide authorization/confirmation for emergency and/or medical treatment for applicant. I/We consent to any X-ray examination, anesthetic, inoculation, vaccination, medical, dental, or surgical diagnosis, or treatment and hospital care to be rendered to the above named minor under general or special supervision and upon the advice of a licensed physician or licensed dentist at any medical facility, in such state where services are rendered should it be deemed necessary. I/We understand this will be done on my behalf should SOLTREKS, Inc., be unable to contact me/us at the time of said emergency. I/We authorize the release of any medical information regarding the applicant to SOLTREKS, Inc. and authorize SOLTREKS, Inc. to release information regarding his/her prior medical history to medical providers as deemed necessary to facilitate the applicant's medical care. I/We are ultimately responsible for the cost of such service, including expenses for the applicant and the staff member who accompanies the applicant during the period of illness and in rejoining the group, medicines and ambulance service, and shall be charged to the parent/guardian and paid by the parent/guardian.

**INITIALS** \_\_\_\_\_

**INITIALS** \_\_\_\_\_

**PRESCRIPTIONS**

I/We understand that all prescribed medications to be taken by the applicant throughout any SOLTREKS, Inc. programs must be in sealed containers (original prescription bottles) and will be in the custody of, and dispensed by, SOLTREKS, Inc. personnel.

**INITIALS** \_\_\_\_\_

**INITIALS** \_\_\_\_\_

**AUTHORIZATION FOR SEARCH**

I/We understand and agree that applicant's personal affects and also his/her person may be searched at the discretion of SOLTREKS, Inc. personnel for the purpose of discovering and confiscating any prescribed or un-prescribed drugs or medications or other items not permitted during participation in SOLTREKS, Inc. programs.

**INITIALS** \_\_\_\_\_

**INITIALS** \_\_\_\_\_

**TURNING 18 YEARS OLD WHILE ENROLLED**

I/We understand that if the applicant turns 18 years old while enrolled at Soltreks, the applicant becomes a legal adult, and it is up to applicant whether he/she completes the program. If the applicant decides to complete the program he/she will be required to sign his/ her own documentation of enrollment. If the applicant decides not to complete the program, Soltreks will assist with discharge.

**N/A** \_\_\_\_\_

**INITIALS** \_\_\_\_\_

**INITIALS** \_\_\_\_\_

**I/WE, THE UNDERSIGNED, HAVE READ AND UNDERSTAND ALL CONSENTS, RELEASES AND AGREEMENTS SET ABOVE AND EXECUTE THEM VOLUNTARILY.**

**Parent/Guardian's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent/Guardian's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of Participant** \_\_\_\_\_ **Date** \_\_\_\_\_

**Applicant's Full Name:** \_\_\_\_\_

**CONFIDENTIALITY**

I/We understand that the information I/We disclose to SOLTREKS, Inc. may be protected under federal and state regulations and cannot be disclosed without my/our written consent unless otherwise indicated in such applicable regulations. These records may include **medical, confidential psychological, counseling, therapeutic and academic information, letters, email updates, treatment plans, and evaluations.** Federal law and SOLTREKS, Inc. recognize the following exceptions:

- Information regarding imminent danger to self or others, criminal activity involving the program or program personnel, or medical emergency.
- Information regarding suspected child abuse.
- Disclosure of information may be allowed by court order under limited circumstances.

I/We have read the policy stated above and acknowledge the rights and limitations upon my/our privacy as guaranteed under the law and through the operating procedure of SOLTREKS.

**INITIALS** \_\_\_\_\_ **INITIALS** \_\_\_\_\_

**AUTHORIZATION FOR THERAPEUTIC HOLD**

SOLTREKS, Inc. personnel may physically hold, control, and detain participants who pose a danger of physical injury or threat of injury to themselves or others. It is understood that any therapeutic hold will be the minimum required and will only be used to insure a participant's safety including, but not limited to: that of other trek participants, instructors, property, or the public. A therapeutic hold may include immobilizing the applicant against his/her resistance in a standing, sitting, or prone position. I/we give express authority and consent to SOLTREKS, Inc. personnel to utilize a therapeutic hold as deemed necessary for the above named applicant.

**INITIALS** \_\_\_\_\_ **INITIALS** \_\_\_\_\_

**GOVERNMENT SERVICES FOR RUNAWAYS**

Should an applicant run away from the supervision of SOLTREKS, Inc. staff during the term of their trek, any appropriate law enforcement or security personnel of any federal, state, county, or municipal government may be contacted, and SOLTREKS, Inc. will abide by their decision as to any search and rescue efforts, apprehension and detention of the applicant. Government authorities may be directed to detain and retain custody of the applicant until SOLTREKS, Inc. personnel or a parent can be contacted. At that time, SOLTREKS, Inc. personnel may re-obtain custody and control of the participant, or may authorize continued custody by the detaining government agency until travel is arranged for the participant to leave the program if necessary.

**INITIALS** \_\_\_\_\_ **INITIALS** \_\_\_\_\_

**WITHDRAWAL, DISCHARGE, AND TERMINATION PROCEDURES**

In the event the Parent(s) withdraws the participant prior to the end date of the trek, the remaining tuition and fees will be assessed for reimbursement. SOLTREKS reserves the right to terminate enrollment at anytime due to illegal, uncontrollable, or excessively dangerous actions by the participant, unreported or previously unknown medical conditions, prior injuries or for any other reason as deemed necessary by SOLTREKS, Inc. the participant's behavior jeopardizes his/her physical or emotional health and/or safety, or that of others. SOLTREKS, Inc. reserves the right to dismiss the student without parental agreement. Dismissal may also result in the event Parent(s) fail to support the applicant in their emotional process throughout the trek. The decision to dismiss under these conditions will be made by the Executive Director after consultation with the staff and the parents. Parent(s) reserve the right to terminate the applicant's enrollment at any time.

**INITIALS** \_\_\_\_\_ **INITIALS** \_\_\_\_\_

**I/WE, THE UNDERSIGNED, HAVE READ AND UNDERSTAND ALL CONSENTS, RELEASES AND AGREEMENTS SET ABOVE AND EXECUTE THEM VOLUNTARILY.**

**Parent/Guardian's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent/Guardian's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of Participant** \_\_\_\_\_ **Date** \_\_\_\_\_

**Applicant's Full Name:** \_\_\_\_\_

**AUTHORIZATION AND CONSENT FOR COMMUNICATIONS**

Applicants and parents communicate through letter writing while in the program. Letters may be sent and received electronically through the Soltreks office to expedite their receipt and to provide an opportunity for supporting staff to provide effective communication suggestions. Letters may be read by and shared with the applicants' instructors and staff as a way to support their personal development process. Applicants and parents will be encouraged to write as often as they like.

I/We understand my/our responsibilities regarding sending and receiving mail during the trek. I/We authorize Soltreks to transmit personal communications from my/our child to me and to review such communications for the purposes stated above. I/We understand that errors may occur in the transmission of personal communication. I/We release Soltreks from any and all liability for errors in the transmission of personal communication between my child and me. I/We agree to keep confidential the nature of any communication that I/we may receive in error, to immediately return or destroy any such communication and to notify Soltreks immediately.

**INITIALS** \_\_\_\_\_

**INITIALS** \_\_\_\_\_

**IMAGE RELEASE**

Pictures may be taken of our applicants and parents for Soltreks' confidential records and for the purpose of sending photos in email updates. I/We also acknowledge and understand that photographs of applicant and his/her group may be taken for the purpose of illustrating Soltreks' activities and programs.

I/We **do agree** to release any images of me or the applicant captured by means of photography while a participant in Soltreks. Soltreks may use the images for email updates and the graduation slide show. I/We release Soltreks from any claims, whatsoever, which arise in connection with such release.

I/We **do agree** to release any images of me or the applicant captured by means of photography while a participant in Soltreks for the purpose of creating a DVD of the applicant's trek for release to the applicant and to distribute the DVD to all the families on the trek. I/We release Soltreks from any claims, whatsoever, which arise in connection with such release.

I/We **do agree** to release any images of me or the applicant captured by means of photography while a participant in Soltreks, without limitation, in connection with any brochure, publicity, marketing, or educational materials. I/We release Soltreks from any claims, whatsoever, which arise in connection with such release.

I/We **do not** grant permission for release of images of me or the applicant.

**INITIALS** \_\_\_\_\_

**INITIALS** \_\_\_\_\_

**APPLICANT ENROLLING AS 18 YEARS OLD**

I, being 18 years old, understand that I am enrolling at Soltreks upon my own free will. I understand that I am required to fill out the enrollment application and sign documents in my own name. I also understand that I can discharge myself from the program at any time.

**Signature of 18 year old** \_\_\_\_\_

**I/WE, THE UNDERSIGNED, HAVE READ AND UNDERSTAND ALL CONSENTS, RELEASES AND AGREEMENTS SET ABOVE AND EXECUTE THEM VOLUNTARILY.**

**Parent/Guardian's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent/Guardian's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of Participant** \_\_\_\_\_ **Date** \_\_\_\_\_

Applicant's Full Name: \_\_\_\_\_

## Optional Psychological Testing

*The application of scientific methods to understanding cognitive, emotional and behavioral functioning*

PSYCHOLOGICAL TESTING SERVICES, INC.  
1417 Haight Creek Dr.  
Kaysville, UT 84037  
(801) 451-2262 office (801) 451-2262 Fax  
E-mail address: [psychologicaltesting@msn.com](mailto:psychologicaltesting@msn.com)

*The assessment procedures used will evaluate the child in three major categories:*

**Cognitive:** IQ and or achievement testing to determine the strengths and weaknesses of a persons thinking in eleven domains including: general awareness, attention, memory, verbal comprehension, visual-spatial ability, computation, abstract thought, impulsivity, problem solving, social comprehension, and judgment. Obtain level of academic functioning and compare results to national norms. Rule out learning disabilities, ADD/ADHD, or nonverbal learning disability. Rule out thought disorders and screen for organic impairment.

**Emotional:** Assess emotional functioning and assess for depression, anxiety, deficits in identity formation, obsessive/compulsive disorders, and sleep disorders. Assess personality functioning. Obtain data regarding developmental and emotional age. Obtain data regarding family dynamics. Evaluates who the child is and why he or she is behaving as they are.

**Behavioral:** Screen for substance abuse. Screen for trauma and abuse. Screen for risk of self-harm, aggression, and treatment compliance or flight. Detect malingering and deceit. Screen for behaviors that are high risk, illegal, or violate the rights of others or major social values.

Psychological evaluations include clinical interviews, a write-up of test results, and consultation with the parents and when requested, with possible aftercare placements. Many boarding schools and residential treatment centers request test results to ensure that they are accepting students for whom they can be most helpful. Consequently, testing is often an important component of treatment and aftercare planning.

### **CONSENT TO ADMINISTER PSYCHOLOGICAL TESTING**

**I hereby agree to psychological testing for the child named below. I understand that all testing protocols and all materials generated from the assessment are the property of Psychological Testing Services, Inc. I understand that information may come to light during this evaluation that must remain confidential, due to the content of disclosure. I understand that the results of the assessment will be used by the staff of Soltreks to enhance treatment of the child named below. Soltreks has my permission to release information to Psychological Testing Services, Inc. and vice versa. Finally, I understand that no information will be shared with anyone else, or any other agency, without my permission. I have listed below other professionals (educational consultant, therapist, etc.) with whom Psychological Testing Services may share test results.**

**NO**, I do not wish to have my child evaluated at this time.

**YES**, please have my child evaluated at an additional cost of \$2,100.00.

Name of minor: \_\_\_\_\_ Relationship to minor: \_\_\_\_\_

Name of parent or guardian: \_\_\_\_\_

Address, City, State, Zip \_\_\_\_\_

Other Professionals who may be contacted regarding test results \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE

**Payment should be made directly to:** Psychological Testing Services, Inc.  
1417 Haight Creek Drive  
Kaysville, Utah 84037

Upon receipt of payment in full, Dr. McRoberts will schedule an appointment for your child's evaluation at Soltreks. If you have any questions, please contact Dr. McRoberts directly at (801) 451-2262.

Applicant's Full Name: \_\_\_\_\_

## Medical and Dental Insurance Information

*Proof of current Medical and Dental Insurance must be provided in the spaces below prior to the applicant's enrollment. Please attach an ENLARGED photocopy of the front and back of your medical and dental insurance cards AND prescription/Pharmacy card if applicable (this allows for Soltreks to refill your child's prescription as needed).*

### Medical Insurance

Name as it appears on Insurance card: \_\_\_\_\_

Please identify name on card:    FATHER        MOTHER        STUDENT        OTHER

Insurance Company: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Policy Holder \_\_\_\_\_ Policy Holder Social Security No. \_\_\_\_\_

Policy No. \_\_\_\_\_ Group No. (If applicable) \_\_\_\_\_

Employer (If group policy) \_\_\_\_\_

Coverage (Outpatient, Major Medical, Mental Health, Hospital) \_\_\_\_\_

Effective Date \_\_\_\_\_ Pharmacy Card Number \_\_\_\_\_ Pharmacy Deductible \_\_\_\_\_

### Dental Insurance

Name as it appears on Insurance card: \_\_\_\_\_

Please identify name on card:    FATHER        MOTHER        STUDENT        OTHER

Insurance Company: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Policy Holder \_\_\_\_\_ Policy Holder Social Security No. \_\_\_\_\_

Policy No. \_\_\_\_\_ Group No. (If applicable) \_\_\_\_\_

Employer (If group policy) \_\_\_\_\_

Coverage (Emergency, preventative, cosmetic, etc.) \_\_\_\_\_

Please understand the Soltreks will make every effort to have your insurance billed for your child's prescription, however, some insurance companies do not cover pharmacies in Minnesota. If you have any questions, please contact the office.

SIGNATURE OF INSURED PARENT \_\_\_\_\_ DATE \_\_\_\_\_

Applicant's Full Name: \_\_\_\_\_

**Applicant Medical History**

**PAGES 16 – 20: TO BE COMPLETED BY A PARENT OR GUARDIAN.**

**Applicant:** Male \_\_\_ Female \_\_\_ Age \_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
Hair Color \_\_\_\_\_ Eye Color \_\_\_\_\_

**APPLICANT PRESCRIPTION MEDICATION INVENTORY**

Soltreks staff holds and dispenses any prescription or non-prescription medication that your child may need. It is critical that Soltreks staff have accurate information about each medication that your child takes as well as adequate medication to last him/her until the last day of trek.

Most medications that an applicant might be taking can be used during their stay at Soltreks. It is important the physician completing the physical be aware of ALL of the medications your child will be taking during any portion of his/her treatment at Soltreks. For this reason, we require this form be completed by parents or guardians aware of current medication needs and reviewed by the physician completing the physical. All physicians providing care need to be aware of all prescription medication your child is taking.

List any current or previous health problems affecting the applicant.

\_\_\_\_\_

**Is the applicant currently on any medications:** Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes, please list medications and dosages. All students on medication must bring a **6 week supply** of prescriptions.

Medication	Date First Taken	Reason for Taking	Dosage & Schedule	Quantity per Day	Total Needed for Trek (42 days)*

**\*Please be sure the quantities in the last column accompany your child upon admission.**

**History of other medication use: please list type and purpose**

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

**PLEASE COPY THE MEDICATION INFORMATION INTO THE TABLE ON PAGE 22 FOR YOUR CHILD'S PHYSICIAN TO REVIEW AND ACKNOWLEDGE DURING HIS/HER PHYSICAL EXAMINATION.**

Applicant's Full Name: \_\_\_\_\_

**ALLERGIES**

**DOES THE APPLICANT HAVE ANY ALLERGIES?**  YES  NO

**Include all known allergies: to medicines, foods, insect bites/stings, etc., include the severity of reaction, specific details of last occurrence, date, precisely what happened, how the incident was controlled.**

Allergy (list below)	Reaction	Date of last occurrence	Medication Required

**Physician's Name** \_\_\_\_\_

Address \_\_\_\_\_

Telephone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

Date of last physical exam \_\_\_\_\_

**Does the applicant wear glasses or contacts?** \_\_\_\_\_  Yes\*\*  No

\*\*Please attach prescription

**Optometrist/Ophthalmologist's Name** \_\_\_\_\_

Address \_\_\_\_\_

Telephone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

Date of last eye exam \_\_\_\_\_

**Does the applicant wear braces or retainers?** \_\_\_\_\_  Yes\*\*  No

\*\*Please describe

**Dentist's Name** \_\_\_\_\_

Address \_\_\_\_\_

Telephone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

**Orthodontist's Name, Address and Telephone if under current treatment** \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Fax ( ) \_\_\_\_\_

**Has the applicant ever been hospitalized?**  Yes\*\*  No

\*\*Reason \_\_\_\_\_ Dates \_\_\_\_\_

Physician \_\_\_\_\_ Hospital \_\_\_\_\_

**Has the applicant ever had surgery?**  Yes\*\*  No

\*\*Reason \_\_\_\_\_ Dates \_\_\_\_\_

Physician \_\_\_\_\_ Hospital \_\_\_\_\_

**Applicant's Full Name:** \_\_\_\_\_

**Has the applicant ever been involved in an accident?**  Yes\*\*  No

\*\*Injuries \_\_\_\_\_  
Date \_\_\_\_\_ Physician \_\_\_\_\_ Hospital \_\_\_\_\_

**Has the applicant ever broken a bone?**  Yes\*\*  No

Please describe \_\_\_\_\_  
Date \_\_\_\_\_ Physician \_\_\_\_\_ Hospital \_\_\_\_\_

**Please list any excessive fears the applicant has had and at what age these fears were experienced (i.e., darkness, thunder, death).**

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

**Has the applicant had any of the following diseases, illnesses, medical problems or disorders? If so, please list age of occurrence next to condition.**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Anemia                      | <input type="checkbox"/> Frequent Ear Infections  | <input type="checkbox"/> Rheumatic Fever                   |
| <input type="checkbox"/> Anorexia/Bulimia            | <input type="checkbox"/> German Measles           | <input type="checkbox"/> STD [Herpes, Gonorrhea, Syphilis] |
| <input type="checkbox"/> Arthritis                   | <input type="checkbox"/> Heart Disorder           | <input type="checkbox"/> Scarlet Fever                     |
| <input type="checkbox"/> Bladder or Kidney Infection | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> Sclerosis                         |
| <input type="checkbox"/> Bone Condition              | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Scoliosis                         |
| <input type="checkbox"/> Chicken Pox                 | <input type="checkbox"/> Meningitis, Encephalitis | <input type="checkbox"/> Ulcers                            |
| <input type="checkbox"/> Constipation                | <input type="checkbox"/> Mononucleosis            | <input type="checkbox"/> Whooping Cough                    |
| <input type="checkbox"/> Convulsions or Seizures     | <input type="checkbox"/> Mumps                    |  |
| <input type="checkbox"/> Dermatitis, Eczema          | <input type="checkbox"/> Muscle Weakness          |  |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Obesity                  |  |
| <input type="checkbox"/> Diarrhea                    | <input type="checkbox"/> Pneumonia, Bronchitis    |  |
| <input type="checkbox"/> Epilepsy                    | <input type="checkbox"/> Polio                    |  |
| <input type="checkbox"/> Frequent Colds/Sore Throats | <input type="checkbox"/> Red Measles              |  |

Other (please describe)

\_\_\_\_\_

**Have any of the applicant's close relatives had any of the following conditions? Please check Yes or No. If yes, please indicate relationship to applicant.**

	<u>Yes</u>	<u>No</u>	<u>Relationship to Applicant</u>
Mental Illness			
High Blood Pressure			
Cardiovascular Disease			
Cancer			
Diabetes			
Muscle Disorder			
Tuberculosis			
Epilepsy or Convulsions			
Kidney Disease			
Bleeding Disorder			

**Applicant's Full Name:** \_\_\_\_\_

Any other illness which runs in your family:

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

**Does the applicant have a drug or alcohol abuse problem?**     Yes     No  
**Previous treatment?**     Yes     No

Facility \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone \_\_\_\_\_ Fax \_\_\_\_\_

What known substances have the applicant used and/or experimented?

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

**The existence of any type of heart irregularity in your child may put him/her at high risk. It is important you are completely forthcoming with any and all information you have regarding the following questions.**

**Has the applicant ever passed out during or after exercise?**

- Yes  
 No

**Has the applicant ever been dizzy during or after exercise?**

- Yes  
 No

**Has the applicant ever had chest pain during or after exercise?**

- Yes  
 No

**Has the applicant had high blood pressure or high cholesterol?**

- Yes  
 No

**Has the applicant ever been told he/she has a heart murmur?**

- Yes  
 No

**Has any family member or relative died of heart problems or a sudden death before age 50?**

- Yes  
 No

**Applicant's Full Name:** \_\_\_\_\_

**Has a physician ever denied or restricted the applicant's participation in sports for any heart problems?**

- Yes
- No

**Has the applicant ever participated in sports? If so, what sport and when:**

- Yes
- No

**Has the applicant ever discontinued their participation due to chest discomfort or shortness of breath?**

- Yes
- No

**Has any physician ever denied or restricted the applicant's participation in sports for any heart problems?**

- Yes
- No

**Has the applicant ever had any cold related injuries or circulation disorders?**

- Yes
- No

**If "Yes" to any of the above questions, please explain:** \_\_\_\_\_

\_\_\_\_\_

**Please list any other pertinent medical information not previously listed and any other important information relating to the medical/health history of the applicant.**

\_\_\_\_\_

\_\_\_\_\_

**Wilderness treatment involves strenuous physical activity. I recognize that failure to fully disclose information may put my child at greater risk. The above information is true and complete to the best of my knowledge. Feel free to call us to consult about any health concerns you may have for your child/participant.**

**I /We hereby give consent for SOLTREKS to confer with all individuals named in this application regarding the applicant's personal and medical history. To the best of my/our knowledge, this information set forth in this application is true and correct.**

**Applicant information provided by (please print)** \_\_\_\_\_

\_\_\_\_\_  
**Parent/Guardian Signature** **Date**

\_\_\_\_\_  
**Parent/Guardian Signature** **Date**

**Applicant's Full Name:** \_\_\_\_\_

## Nutritional Screening

Applicant's age:

Brief description of applicant's current diet:

Does the applicant have food allergies? Yes  No

If yes, please describe:

Any non-allergy dietary requests: \_\_\_\_\_

What type of reaction does the applicant have? When was the last reaction? How long did it last? What intervention was used?

Does the applicant eat Breakfast  Lunch  Dinner  Snacks

Does the applicant eat with his/her family?

Does the applicant have a medical condition that would warrant a special diet?

If yes, please explain:

Does the applicant have any eating disorders? Yes  No

If yes, please describe:

\_\_\_\_\_  
Signature of person completing this form

Applicant's Full Name: \_\_\_\_\_

## Payment Agreement

### Tuition Information

Soltreks is a private pay company. We do not bill insurance companies. Daily tuition applies to every day your child is enrolled at Soltreks. The tuition fee varies based upon the trek (see Schedule of Fees).

An application process fee of \$150 must accompany the review of this application. Once notified of acceptance, a non-refundable deposit of \$2500 will be due to secure enrollment. Payment for the first 30 days is required at least 3 days prior to the trek. Payment options include: Certified bank checks, personal checks, wire transfers, or credit cards (VISA or MasterCard).

Average length of stay is six-eight weeks. All extensions beyond your initial payment will be billed at the quoted day rate, and will be billed to the credit card listed below.

### Incidental and Medical Expenses

Please include your credit card information on the **CREDIT CARD AUTHORIZATION FORM** and fax to accounting at **707.549.3785** to be kept on file. Incidental expenses and extensions will be charged to your account unless prior arrangements have been made with the accounting department. **Should your insurance require co-pay, or if you have not provided your child's medical/prescription insurance information as well as an enlarged copy of the front and back of your card, you will be charged directly for ALL medical expenses associated with your child during his/her stay at Soltreks. Parents/legal guardians shall, however, in all events be ultimately liable for all medical costs associated with your child regardless of any asserted non-liability by insurers.** Credit card is required for incidental and medical expenses, even if tuition is paid by other form of payment.

### Additional Fees

Optional services that are NOT covered by Soltreks tuition are: medicine refills and any additional doctor, dentist, specialized medical services or mental health testing appointments. Fees for all of these services will be billed directly to you. Transportation assistance outside of the initial pickup will be billed as quoted. Psychological testing services are not covered by tuition, but can be requested for an additional fee.

### Insurance Information

Soltreks does not bill insurance companies directly. We are a private pay program. Some plans may cover the cost of your child's clinical therapy while he/she is enrolled in Soltreks. Please contact your medical insurance for reimbursement options prior to enrollment. Insurance companies may require a medical referral or pre-authorization. If a medical referral or pre-authorization is needed, contact your child's home psychiatrist and/or medical physician to issue a referral or pre-authorization for outdoor therapy. Soltreks does not provide pre-authorization for treatment. Please let the insurance companies know that you, the insurance holder, will be paying Soltreks upfront and that any reimbursement needs to be paid directly to you. Soltreks respects your family's right to confidentiality. Therefore, after your child's stay, we will provide you upon request, information for you to submit to your insurance company: a breakdown of program costs; services rendered, including CPT codes and diagnosis; your child's therapist's name and credentials. Soltreks does not work as a liaison between you and your insurance company.

**Applicant's Full Name:** \_\_\_\_\_

**Multiple Sibling Discounts**

A tuition discount of 10% is given for the second child from the same family who enrolls. A tuition discount of 15% is given for the third child from the same family who enrolls. Concurrent enrollment of multiple children from the same family is not required to be eligible for the discount.

**Method of Payment**

Please select one of the following:

- Credit Card: *PLEASE COMPLETE CREDIT CARD AUTHORIZATION FORM***  
Please bill my credit card for the initial tuition amount of \$ \_\_\_\_\_. All extensions beyond your initial payment will be billed at the day rate quoted and will be billed to the credit card.

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- Check Payable to Soltreks**  
Please send payment to: Soltreks, Inc., 2346 Highway #3, Two Harbors, MN 55616  
Check Number: \_\_\_\_\_ USPS/FEDEX tracking number \_\_\_\_\_

- Wire Transfer** (Please include student's name and fax wire transfer confirmation to 218.834.4607)  
Soltreks, Inc. Swift Code: WFBIUS6S, Routing Number: 121000248, Account No: 6860044749  
Wells Fargo Bank, 622 1<sup>st</sup> Ave., Two Harbors, MN 55616

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Financial Sponsor (If different than parent, print please):** \_\_\_\_\_

**Sponsor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Applicant's Full Name: \_\_\_\_\_

<b>Schedule of Fees</b>
-------------------------

\$150.00 non-refundable	<b>Application Processing Fee</b>
\$2500.00 non-refundable	<b>Enrollment Fee</b> ( <i>Due upon acceptance to secure placement</i> )
\$1,000.00	<b>Soltreks Clothing and Gear Package</b> ( <i>Soltreks provides all clothing and equipment; applicant keeps all personal clothing (base layers) with the exception of raingear and winter items: boots, mitts, jacket, and snowsuit</i> ) <b>Applicants must provide their own undergarments and bathing suits.</b> <b>Shirt Size</b> ( <i>circle one</i> ) XS, S, M, L, XL, XXL <b>Shoe Size</b> _____ <b>Pant Size</b> ( <i>circle one</i> ) XS, S, M, L, XL, XXL <b>Inseam</b> _____
\$420 per day	<b>Open Enrollment &amp; Summer Program Day Rate</b> ( <i>Average length of stay is six - eight weeks</i> )
\$495 per day	<b>One-on-One Trek</b>
Upon quote.	<b>Additional Services</b> ( <i>i.e., airport, assist applicant with travel</i> )

**Tuition Includes:**

Initial clinical screening, individual and group psychotherapy, wilderness therapy, psycho educational groups, parent consultation and support, intense outdoor learning experience and individual challenge experience, weekly family services and support, individualized treatment planning, treatment coordination and planning with other professionals, supportive aftercare planning, specialty outdoor group gear and equipment, all food, therapeutic curriculum (2.5 high school academic credits), official transcript, parent workshops, and family conference and graduation.

**Soltreks Clothing and Gear Package:**

With this package, the student will receive new personal clothing (base layers) that remains their own, with the exception of the seasonal rental gear including winter boots, winter mitts, winter jacket, snowsuit and raingear. **Applicants must provide their own undergarments and bathing suits.**

**Interest and Collection:**

Late payments will accrue finance charges at 12% APR on all outstanding charges over fourteen (14) days unless arrangements are made with accounting. If fee is not paid in full, sponsor will be referred to a collection agency for the remaining balance.

**I have read and understand my financial obligations as outlined above and agree to these conditions.**

\_\_\_\_\_  
Signature of Financial Sponsor

\_\_\_\_\_  
Date

Applicant's Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

**Physical Examination**

**TO BE COMPLETED BY EXAMINING PHYSICIAN.**

This applicant is being considered for participation in a physically and emotionally challenging, wilderness program which will involve rigorous, extended exercise, sometimes under very hot or quite cold conditions. Temperature conditions may sometime be very hot or quite cold at elevations ranging from 50 feet (Minnesota) to 9000 feet (New Mexico). He/She may participate in activities that include, but are not necessarily limited to: backpacking, sea kayaking, canoeing, snowshoeing, cross country skiing, hiking, rock climbing, high ropes course, service learning or work projects, all season camping, or other experiential activities. While SOLTREKS, Inc. requires appropriate clothing and gear, and provides an adequate diet, participants may be cold or hot for several hours at a time, or may be without water for a number of hours. They may backpack or hike a minimum of 3 miles a day at the beginning of the trek, and up to 10 miles a day near the end of the trek. Participants will also be several hours or up to a day from medical care [dependant upon injury/illness and location] and may experience a medical emergency, such as an asthma attack, dehydration, hypo/hyperthermia, etc.

Given the information provided above, your thorough physical examination and awareness of ALL medications that have been prescribed to this applicant and their use in a wilderness environment is important. SOLTREKS would appreciate your assessment of this applicant for program participation. Most health problems, if under control and known to our staff and instructors, can be managed. Should a medical concern or limitation be in question, please note those limitations with a plan of action for managing the medical concern. Feel free to call us at (218) 834-4607 to consult about any health concerns you may have about this applicant, or for further information about our program.

Medication	Date First Taken	Reason for Taking	Dosage & Schedule	Quantity per Day	Total Needed for Trek (42 days)*

**\*Please be sure the quantities in the last column accompany the child upon admission.**

**I am aware of and have reviewed all of the medications this patient is taking. I am aware of the Black Box Warnings in the Physician's Desk Reference (PDR) for each of these medications, and this client is still appropriate for the physical and emotional challenges of this trek.**

**Name of Physician:** \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_

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

**Applicant's Full Name** \_\_\_\_\_

**Date of this exam** \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Head \_\_\_\_\_

Eyes: Glasses/Contacts \_\_\_\_\_ Vision: Right \_\_\_\_\_ Left \_\_\_\_\_

Ears \_\_\_\_\_ Whisper Hearing Test \_\_\_\_\_

Nose/Throat \_\_\_\_\_ Neck/Lymph \_\_\_\_\_

Chest \_\_\_\_\_ Heart \_\_\_\_\_

Abdomen \_\_\_\_\_ Genitalia/Hernia \_\_\_\_\_

Neurological \_\_\_\_\_ Muscular skeletal \_\_\_\_\_

Scoliosis \_\_\_\_\_

Pelvic/Breast Exam \_\_\_\_\_

Please list all current medical problems under treatment. \_\_\_\_\_

Please note any physical limitations or impairments that would limit the applicant's ability to participate in the mentioned activities. Suggestions for medical management: \_\_\_\_\_

Please list any allergies the applicant has experienced, as well as reactions/medications.

**REQUIRED LABORATORY TESTS AND IMMUNIZATIONS –All test results must be attached to this form.**

If sexually active or suspected sexually active, the following tests are required:

- Pregnancy Test
- Viral Hepatitis Screen (A & B)
- Sexually Transmitted Diseases (including HIV)

Required for **All** applicants:

- Hemoglobin
- Hematocrit Level
- Urinalysis
- Tetanus (Within past 5 years)

Significant findings/recommendations \_\_\_\_\_

**IMMUNIZATION HISTORY** Please include a copy of the applicant's immunization history.

**All test results must be attached to this examination prior to enrollment in SOLTREKS.**

Based on your examination and the applicant's medical history and thorough knowledge and understanding of the applicants prescribed medication, the above named applicant is cleared for participation in SOLTREKS as follows: Full participation in all activities (backpacking, snowshoeing, cross country skiing, sea kayaking, canoeing, rock climbing, high ropes course, all-season camping, work projects).

YES \_\_\_\_\_ NO \_\_\_\_\_ Limited participation – restricted activities are: \_\_\_\_\_

**Physician's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Physician's Name** (please print) \_\_\_\_\_

**Physician's Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Telephone Number** \_\_\_\_\_ **Fax** \_\_\_\_\_