TRAIL GROUPS & MEDICAL/DIETARY ALERTS
SANTA MONICA MOUNTAINS INSTITUTE

TO BE FILLED OUT BY THE GROUP COORDINATOR

GROUP NAME: _____ **PROGRAM DATES:** _____

HEAD CHAPERONE NAME: _____

CAREFULLY REVIEW **REGISTRATION FORMS** FROM EACH PARTICIPANT AND CHECK FOR SIGNATURE BY PARENT OR LEGAL GUARDIAN. **ALL FORMS MUST BE SIGNED**. PLEASE LIST BELOW THE MEDICAL ALERTS **OR CONDITIONS** (HEALTH PROBLEMS, ALLERGIES, RECENT SURGERIES, INJURIES OR ILLNESSES, MEDICATIONS, ETC.) AND DIETARY RESTRICTIONS **OR CONDITIONS** FOR YOUR GROUP. BE SURE TO INCLUDE PARTICIPANT'S NAME. YOUR SIGNATURE BELOW CERTIFIES THAT YOU HAVE COLLECTED **ALL** OF THE REGISTRATION FORMS FOR PARTICIPANTS OF THE SANTA MONICA MOUNTAINS INSTITUTE PROGRAM, AND THAT YOU WILL DELIVER THEM TO SANTA MONICA MOUNTAINS INSTITUTE PERSONNEL PRIOR TO YOUR PROGRAM. **BY SIGNING, YOU ACCEPT FULL RESPONSIBILITY FOR ANY ERRORS OR OMISSIONS. THIS FORM MUST BE SIGNED, COMPLETED AND RETURNED TO OUR OFFICE AT LEAST 30 DAYS PRIOR TO YOUR PROGRAM DATE.**

HEAD CHAPERONE: _____ **DATE:** _____
(SIGNATURE)

MAKE COPIES OF THIS SHEET AS NEEDED.

PAGE: _____ **OF:** _____

TRAIL GROUP
(PLEASE PRINT NAMES CLEARLY)

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CHAPERONE(S) _____

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MEDICAL OR DIETARY ALERTS
(PLEASE BE SPECIFIC)

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TRAIL GROUP
(PLEASE PRINT NAMES CLEARLY)

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MEDICAL OR DIETARY ALERTS

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