Elevation Outdoors Experiential Programs Association

P.O. Box 20071 Towne Centre
Kelowna, BC
V1Y 9H2

Skateboard Program Application Form

Name of Youth: ___________________________________

Age (as of Sept year applying): _________________ Pronouns:___________________

How did you hear about us? ____

Place of residence/address (**and postal code**):

____

Do you identify as an individual within the BIPOC community? All information will be kept confidential in accordance with federal law and does not affect your eligibility for our programs, we collect this information to provide participant demographics to our funders.
(circle one) **Y** **N**

If you answered yes, **please circle**:
Metis - First Nations – Inuit – Other – Unknown – Prefer not to answer

Are you a first-time skateboarder? (circle one): **Y** **N**

If no, how many days of experience have you had and how long ago?
____

Please give reasons **why** you want to participate in the skateboard program (youth's words only please):
____

Can you be available every Tuesday and Thursday evening from mid-September until mid-October?
(circle one) **Y** **N**

Please list any previously known conflicts with these days:
____

Please enter youth's height, weight, shirt and shoe size (for supply and rental purposes):
____

Elevation Outdoors Experiential Programs Association

P.O. Box 20071 Towne Centre
Kelowna, BC
V1Y 9H2

Parent/Guardian Email Address (this is where we will send notice of acceptance into the program and program information once accepted):

____

Pick Up Location
Please indicate which of our central locations you would like to be picked up and dropped off at, for transport to the mountain:
__ Xtreme Theatre West Kelowna parking lot (beside Dairy Queen)
__ Orchard Park bus loop
__ Rutland Shell (Gerstmar and Hwy 33)
__ Rutland 7-11 (Rutland Rd and Hwy 33)

Type of Spot
Please indicate the type of spot you are applying for:
__ Paid spot ($250/participant - invoice will be sent once participant has been accepted into the program)
__ Full scholarship spot (please attach proof of eligibility, see below)
__ Partial scholarship spot (if you are not eligible for a full scholarship seat but would like to inquire about partial support, please select this option and we will follow up with you to discuss options!)

* If applying for a scholarship seat, please email proof of eligibility to programs@elevationoutdoors.ca.
To see our eligibility criteria, and approved documents, please visit http://www.elevationoutdoors.ca/programs/ (and scroll down on the web page).

Google Calendar Sharing

Elevation Outdoors has permission to share Google Cal dates with my and/or my child's email address (leave blank if not interested).

Parent's email address: ____

Youth's email address: ____

Initial_______ I give permission to Elevation Outdoors to contact me about future programs and opportunities that come available. Initial_______ I give permission for Elevation Outdoors to provide my contact information to the Canadian Tire Jumpstart Foundation. As partial funders for this program they like to be able to contact you directly with future opportunities.

Elevation Outdoors Experiential Programs Association

P.O. Box 20071 Towne Centre
Kelowna, BC
V1Y 9H2

Video and Photographs

Elevation Outdoors has permission to use my or my child's photograph/video/audio recordings to promote the organization. I understand that the images may be used in various formats not limited to print publications, online publications, presentations, websites, and social media.
Yes No Initial_____

Contacting Youth

Elevation Outdoors has permission to contact my child by phone (text or call) to confirm program attendance and to communicate with as need arises, during or between program dates.
Yes No Initial_____

Youth phone number: ___________________________________

Elevation Outdoors Experiential Programs Association

P.O. Box 20071 Towne Centre
Kelowna, BC
V1Y 9H2

Participant's Medical Form

Name of Youth: ___________________________

BC Med Care Card #___________________________

Date of birth (year, month, day): ________________________

Parent/Guardian's name: _________________________________

Address: ____

Phone # (hm)_______________(wk)_______________(cell)__________

Emergency contact name: _____________________ ph #_________

Medical History
(please circle yes 'Y' or no 'N' to the following questions)

1. Has your child ever suffered any form of **Asthma? Y N**
If yes, do they take any medication for it? What type?
____

2. Has your child ever suffered any form of **Allergy? Y N**
If yes, what are they allergic to and what, if any, medication is taken?
____

3. Does your child have any of the following conditions?

Phobias **Y N** Diabetes **Y N**
Previous concussion(s) **Y N** Bleeding disorder **Y N**
Heart condition **Y N** Migraines/headaches **Y N**
Seeing disorders **Y N** Hearing disorder **Y N**
Epilepsy **Y N** Ankle/knee/joint problems? **Y N**

Please provide details of questions for which 'yes' was
answered: ____
____
____

4. Date of last Tetanus injection? ___________________________
(if not within last 10 years, participant may receive a tetanus injection by a medical officer if they receive a tetanus prone wound)

Please finish on next page.

Elevation Outdoors Experiential Programs Association

P.O. Box 20071 Towne Centre
Kelowna, BC
V1Y 9H2

5. Is your child on any ongoing medications?

Please provide details of medications, dosage and frequency taken:
____
____
____

Do you give permission to your child to self-administer these medications? **Y / N**

6. Do you give permission for your child to be given non-prescription medications for the following conditions?
Pain/fever (e.g. Tylenol, Advil) **Y N**
Cold/flu tablets **Y N**
Bites/stings/hay fever/allergy (e.g. antihistamine) **Y N**

7. Is there anything about your child's situation that we need to be aware of in regards to his/her participation in this program (example: Behaviour or medical concerns)? **Y N**
If Yes, please explain:

8. In the case of accident or illness, I authorize the caregiver to administer first aid and/or be taken to the nearest emergency center. I consent for my child to receive medical treatment. I consent that in the event of severe illness/injury the means of transportation may be by
ambulance at a cost to myself. **Y N**

_______ Initial

I declare that the information which I have provided on this for is complete and correct and that I will notify the program if any changes occur. I authorize the facilitator who is with my child to consent, where it is impractical to communicate with me, for my child to receive such medical or surgical treatment as may be deemed necessary.

Signed ______________________(parent/guardian)

Date _____________