



OFFICE USE ONLY:

Registration # _____ Cabin # _____
Amt. encl. \$ _____ Check # _____

**“Cook Like a Wild Woman”
Registration Form
August 22 & 23, 2009**

Only one person may register per form. Please photocopy for additional registrations.

PLEASE PRINT LEGIBLY

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Work: _____ Home: _____

Email address: _____

The applicant, by signing below, recognizes that the program involves some risk and that she/he takes responsibility for all action or injury that may result by participating. I understand that photographs and/or filming may occur during the sessions and may be used in future support of the program.

Applicant signature: _____

ROOMMATE PREFERENCE (list up to 2): _____

FEE: \$60. Includes instruction, cooking materials, recipes, lunch and dinner on Saturday, brunch on Sunday and lodging. FEE DUE WITH REGISTRATION, SPACE IS LIMITED TO 20, RESERVE YOUR SPOT EARLY!

PLEASE INDICATE METHOD OF PAYMENT:

Check – Total Amount: \$ _____ Payable to: N.H. Wildlife Trust (one check per registration)

Visa MasterCard Exp. date: ____/____ Signature _____

Credit Card # _____ Total Credit Card Amount: \$ _____

I would like to donate to the NH BOW Scholarship Fund: \$25.00 \$50.00 other \$ _____
Your name will be included on the sponsorship list.

REMIT PAYMENT ALONG WITH REGISTRATION FORM AND MAIL TO:

BOW c/o N.H. Wildlife Federation
54 Portsmouth St.
Concord, NH 03301

NO REGISTRATIONS WILL BE ACCEPTED BY TELEPHONE, FAX OR E-MAIL



Becoming an Outdoors-Woman Program
Co-sponsored by
New Hampshire Fish and Game Department and
New Hampshire Wildlife Federation



BECOMING AN OUTDOORS-WOMAN

Medical History Questionnaire

All Information is Confidential

Name _____ Date of Birth _____

Physician _____ Phone # _____

Emergency Contact Name _____ Phone# _____

QUESTIONS:

Please check any of the following medical conditions that apply to you:

- Yes No Are you allergic to any medication (aspirin, penicillin, etc.)? List _____
- Yes No Do you take any medication critical to your health? List _____
- Yes No Have you ever been told by a doctor that you have epilepsy? When _____
- Yes No Have you had recent surgical operations, accidents or injuries? When/What? _____
- Yes No Have you been "knocked out" unconscious, had a concussion or head injury? When? _____
- Yes No Are you pregnant? _____

Do you wear: glasses? or contact lenses?

Date of last tetanus immunization: _____

Please check any of the following medical conditions you have had within the last five years:

- Hay fever or allergies. (Especially to bee's, ants, etc.) If yes, please list _____
If yes, do you carry an epi pen? Yes No
- Heart Disease Diabetes Fainting spells
- Asthma Seizures High blood pressure

Do you have any medical training?

- Doctor Nurse Emergency Medical Technician Other _____

Is there anything else about your health you would like us to know in case of an emergency? _____

Signature _____ Date _____

PLEASE RETURN THIS QUESTIONNAIRE WITH YOUR REGISTRATION FORM.