

REGISTRATION AND MEDICAL RELEASE FORM 2002 HERITAGE EXPEDITIONS TRICERATOPS DIG

Participants must be 12 years of age or older. Persons under the age of 18 must be accompanied by a paying adult. You may register for one or more events. The total registration fee per person will be the combined cost of the events you register for. Participation is limited to 8 persons per session. Spots are reserved on a first come, first serve basis. In case the event(s) you have chosen are full, you will be notified of other available openings.

In order to reserve your spot, payments must be made in full (check or money order) to the USDA Forest Service and sent with your registration. The Registration and Medical Release Form must be received by June 1, 2002. Registration fees are nonrefundable after June 1, 2002. Please mail your payment and registration to:

**2002 Heritage Expeditions Triceratops Dig
C/O Dakota Prairie Grasslands
240 West Century Avenue
Bismarck, ND 58503.**

Name _____

Address _____

City _____

State/Province _____

Country _____

Postal/Zip Code _____

Telephone Number _____

Fax Number _____

EMAIL Address _____

Please register me for the following 2002 Triceratop event(s): (Use One Form per Person)

____ EVENT 1: July 13, 14, 15 (Sat., Sun., Mon.) 2002 Triceratops Dig. \$480/person (all ages).

____ EVENT 2: July 16, 17 (Tues., Wed.) 2002 Triceratops Dig. \$320/person (all ages).

____ EVENT 3: July 18, 19 (Thurs., Fri.) 2002 Triceratops Dig. \$320/person (all ages).

____ EVENT 4: July 20, 21 (Sat., Sun.) 2002 Triceratops Dig. \$320/person (all ages).

TOTAL REGISTRATION FEE ENCLOSED: \$ _____

Please complete the following information regarding dietary needs and emergency medical information:

Name _____

Address _____

Telephone: _____

Do you have any food allergies? Yes No

If yes, please list:

Do you have any special dietary needs? Yes No

If yes, please list: (i.e. vegetarian, diabetic, or other food related needs)

IN CASE OF AN EMERGENCY, PLEASE CONTACT THE FOLLOWING PERSON(S):

Name: _____ Name: _____

Telephone: _____ Telephone: _____

Relationship: _____ Relationship: _____

Are you taking any medication regularly now? Yes NO

If yes, please list:

Are you allergic to any medications? Yes No

If yes, please list medications you are allergic to:

Are you under a doctor's care for any condition now? Yes No

If yes, please list condition, doctor's name, and doctor's telephone number:

Please provide us with health insurance information so that we may provide this to the health care provider, in case of an accident or illness related emergency: (Attach copy of health insurance identification card).

Insured Name: _____

Health Insurance Carrier: _____

Carriers Address: _____

Policy and/or ID Number: _____ Carriers Phone Number: _____

* Other forms may be required later (i.e. volunteer agreements form/liability release).