Dominica Hotel & Tourism Association

HikeFest 2025 - "Exploring Nature's Playground"

Registration Form

Date	Hike Name	Duration	Level
Sat, May 03, 2025	**Warm Up – Middleham Falls**	2 hours	Moderate
Sat, May 10, 2025	**Segment 3 (part) Giraudel to Wotten Waven**	4 hours	Moderate
Sat, May 17, 2025	**Challenge – Morne Diablotin**	6 hours	Difficult
Sat, May 24, 2025	**Night Hike – Syndicate Nature Trail**	1.5 hours	Easy
Sat, May 31, 2025	**Grand Finale – Victoria Falls**	2 hours	Moderate

Participants gather at the Prevost Cinemall Courtyard for 5:30am.

Contact Details:

Name: _____

Address: _____

Phone: (W) _____ (H) _____ (M) _____

Email: _____

Participation Choices (please tick):

[ ] **Sat, May 3th** [ ] **Sat, May 10th** [ ] **Sat, May 17th** [ ] **Sat, May 24th** [ ] **Sat, May 31st**

Price Per Hike: **ECD$75**

T-shirt (please tick): [ ] **S** [ ] **M** [ ] **L** [ ] **XL**

Registration Includes: Transportation (Round trip), guides, security and facilitators, T-Shirts, Sponsor paraphernalia, water, coffee/tea. Hikers will be accompanied by certified tour guides, medical personnel and police escorts.

*Food and drinks will be available for sale after each hike (**NOT** included in cost of hike).

Plus great prizes to be won!!!

Payment Method:

[ ] Cash [ ] MoBanking [ ] Cheque_____ Receipt Issued #: _____

Statement Release

I hereby acknowledge that the Dominica Hotel & Tourism Association as well as, the partners & sponsors of **HikeFest,** organized for four Saturdays in May (**May 03rd, 10th, 17th, 24th, and 31st 2025**) are not responsible for any injuries, accidents, loss or misfortune or any other claims or act of God related to this event.

Medical Record

Mark any illness or conditions that you may have or have had in the past.

- ☐ *Asthma*
- ☐ *Diabetes*
- ☐ *Heart disease*
- ☐ *High blood pressure*
- ☐ *Other* _____

Mark any medicines you are taking.

- ☐ *Heart medicines*
- ☐ *Blood pressure medicines*
- ☐ *Blood thinners such as Coumadin*
- ☐ *Breathing medicines*
- ☐ *Insulin*
- ☐ *Other over the counter medicines such as antacids, laxatives or pain medicines*

Mark any allergies you have.

- ☐ *Dairy products such as eggs or milk*
- ☐ *Seafood*
- ☐ *Dye or iodine*
- ☐ *Aspirin*
- ☐ *Other* _____
- ☐ *Penicillin*
- ☐ *Morphine*
- ☐ *Latex*

TREATMENT GIVEN *(Describe first given and materials used):*

_____

_____

FURTHER TREATMENT REQUIRED *(If taken to hospital, doctor or health centre):*

_____

_____

I hereby accept the terms and conditions and signed that the above is true.

_____

Participant Signature and Date