Medical Information
General Outdoor Recreation Programs

Name of Participant: _____ Birth date: ___/___/___

Parent/Guardian Name (*if applicable)*:_____

Address:_____

City, State, Zip:_____

Phone #: _____ *(Home)* _____*(Cell)*_____*(Business)*

Photo and Video Release

PLEASE READ & SIGN: As part of the consideration tendered for myself (or my child/ward, having not attained the age of 18) being permitted to participate in _____ on _____, I hereby authorize Cleveland Metroparks to use, reproduce, and/or publish photographs and/or video that may pertain to me (or my child/ward, having not attained the age of 18) — including my (or my child/ward) image, likeness and/or voice without compensation. I understand that this material may be used in various publications, public affairs releases, recruitment materials, broadcast public service advertising (PSAs), multimedia exhibits or for other related endeavors. This material may also appear on Cleveland Metroparks or project sponsor's Internet Web Page and/or digital social media services.

By signing this form, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release all claims against any person or organization utilizing this material **(if the participant is under 18 years of age, the parent/guardian must sign).**

Signature: _____Date: _____

Authorization to pick participant up from program (when applicable)

Please list the people who are authorized to pick your child up from the program (*including yourself). If they are not on this list, we will not release your child to them. They must be prepared to show proper identification.

Name of Participant: _____

Name (*please print*) *	**Relationship to participant**
_____	_____
_____	_____

Signature: _____Date: _____

Emergency Contact

Emergency Contact Name: _____Relationship (optional): _____

Address: _____

City, State, Zip: _____

Phone #: _____ *(Home)* _____ *(Cell)* _____ *(Business)*

Personal Medical History List any allergies, including reactions to insect bites/stings and food that you (or your child/ward) have: _____

_____

Are you (or your child/ward) taking any medication(s)? □ Yes □ No If yes, please list:

Medication/Dosage	Reason/Ailment
_____	_____
_____	_____

Have you (or your child) had in the past or currently have any of the following:

□ ADD/ADHD	□ cognitive delays	□ learning disability	□ modified diet
□ autism	□ allergies	□ recent injury/surgery	□ limited mobility
□ extreme fears	□ deaf/hard of hearing	□ blind/low vision	□ separation anxiety
□ diabetes	□ other		

If yes, please explain:

_____

What special accommodations are required for the above conditions:

_____

List any other history of medical problems or special circumstances we should be aware of:

_____

Medical Insurance Company: _____

Physician:_____ **Phone #:** _____

Authorization, Signature and Consent to Treat

PLEASE READ & SIGN: In the event of injury or illness, authorize on behalf of myself (or my child/ward, having not attained the age of 18) Cleveland Metroparks to obtain first aid and/or medical treatment at the nearest and most adequate facility of Cleveland Metroparks choice. This medical treatment authorization is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances for myself (or my child/ward) (**if the participant is under 18 years of age, the parent/guardian must sign**).

Signature: _____Date: _____