



# YOUTH ATTENDEE WAIVER PACKET

(3 forms per person)

Please complete and mail back to Cleveland Metroparks Zoo no later than eight (8) days prior to your scheduled program date.



**CLEVELAND METROPARKS/ CLEVELAND METROPARKS ZOO  
MEDICAL INFORMATION AND CONSENT  
TO TREATMENT (YOUTH ATTENDEE)**

**Information**

Name of Participant: \_\_\_\_\_ Birth date: \_\_\_/\_\_\_/\_\_\_ Gender: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Business)

Date(s) of activity: \_\_\_\_\_ Email: \_\_\_\_\_

Name of activity: SCOUT NIGHT OVERNIGHT PROGRAM

**Emergency Contact Information** (Please circle the number to call first in an emergency)

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Business)

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Business)

**Medical History**

Date of participant's last Tetanus Vaccine (Within past 10 years) \_\_\_\_\_

Is your child/ward up to date on vaccinations required by your child's school district?  Yes  No

If no, please explain. \_\_\_\_\_

List any special dietary needs that your child/ward has: \_\_\_\_\_

List any allergies your child/ward has, including reactions to insect bites, food allergies, and reactions or allergies to bug spray, sunscreen or other topical products:

\_\_\_\_\_

Have any of these allergies resulted in anaphylaxis?  Yes  No

If yes, will your child/ward be bringing an epinephrine injector to the Cleveland Metroparks program?

Yes  No



Is your child/ward taking any medication (oral or topical prescription or nonprescription)?  Yes\*  No

If yes, please list:

Medication/Dosage	Reason/Ailment
_____	_____
_____	_____

Does your child require a special accommodation from Cleveland Metroparks for any reason in order to participate in the program?  Yes  No

If so, please describe the accommodation requested:

\_\_\_\_\_

List any other history of medical problems or special circumstances Cleveland Metroparks should be aware of: \_\_\_\_\_

\_\_\_\_\_

**Medical Insurance Company:** \_\_\_\_\_

**Physician:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Dentist:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Authorization, Signature and Consent to Treat**

In the event of injury or illness, I authorize on behalf of my child/ward, having not attained the age of 18 Cleveland Metroparks to provide first aid and/or medical treatment to my child/ward or to obtain first aid and/or medical treatment for my child/ward at the nearest and most adequate facility of Cleveland Metroparks' choice.

This medical treatment authorization form is completed and signed of my own free will and authorizes medical treatment for my child/ward.

\_\_\_\_\_  
Participant name (please print)

\_\_\_\_\_  
Parent Name

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date



**CLEVELAND METROPARKS/ CLEVELAND METROPARKS ZOO  
LIABILITY WAIVER (YOUTH ATTENDEE)**

**Information**

Name of Participant: \_\_\_\_\_ Birth date: \_\_\_/\_\_\_/\_\_\_ Gender: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Business)

Email: \_\_\_\_\_

Name of Activity/Program: SCOUT NIGHT OVERNIGHT PROGRAM

Date(s) of activity: \_\_\_\_\_

**PLEASE READ CAREFULLY**

**Waiver of Liability and Signature**

I recognize and acknowledge that there are risks associated with the aforementioned activity/program (the "Activity"), and my child/ward should not engage in the Activity unless medically able to do so. I assume all risks associate with the Activity, including but not limited to: falls; trips; contract with equipment or materials; effects of weather; contact with other participants, the natural environment, hazardous materials, and animals, which may act in unpredictable ways. I understand that neither Cleveland Metroparks, nor any of its commissioners, officers, employees, agents, volunteers or sponsors assume any responsibility or liability with respect to my child/ward's participation in the Activity. As part of the consideration tendered for my child/ward being permitted to participate in the Activity, I agree to and do hereby waive any and all claims against, and agree to fully release, hold harmless, and indemnify, the Board of Park Commissioners of the Cleveland Metropolitan Park District, its officers, employees, agents, sponsors, and volunteers (the "Releasees") from any and all claims related to any illness, injury, including loss of life, property damage, or loss of any other description which I may sustain arising out of, or in any way associated with, participation in the Activity, even though liability may arise out of the negligence or carelessness of the Releasees.

\_\_\_\_\_  
Parent/Guardian Name

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



**CLEVELAND METROPARKS/ CLEVELAND METROPARKS ZOO  
MEDIA WAIVER (YOUTH ATTENDEE)**

*(This form must be completed and returned to the program administrator before any program participation)*

Participant's Name \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Parent/Guardian Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone #: \_\_\_\_\_ (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Business)  
Name of Group/School (if applicable) \_\_\_\_\_

Name of Activity/Program \_\_\_\_\_ **SCOUT NIGHT OVERNIGHT PROGRAM** \_\_\_\_\_  
Date(s) of Program: \_\_\_\_\_

**PLEASE READ CAREFULLY**

I hereby authorize Cleveland Metroparks to use, reproduce, and/or publish photographs and/or video that may pertain to my child/ward including 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, including for commercial purposes. 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.

- I AGREE (please sign below)**
- I DISAGREE (please sign below)**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



# **ADULT ATTENDEE / CHAPERONE**

## **WAIVER PACKET**

(3 forms per person)

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**CLEVELAND METROPARKS/ CLEVELAND METROPARKS ZOO  
 MEDICAL INFORMATION AND CONSENT  
 TO TREATMENT (ADULT ATTENDEE)**

**Information**

Name of Participant: \_\_\_\_\_ Birth date: \_\_\_/\_\_\_/\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Business)

Date(s) of activity: \_\_\_\_\_ Email: \_\_\_\_\_

Name of activity: SCOUT NIGHT OVERNIGHT PROGRAM

**Emergency Contact Information** (Please circle the number to call first in an emergency)

3. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ (Home) \_\_\_\_\_ (cell) \_\_\_\_\_ (Business)

4. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ (Home) \_\_\_\_\_ (cell) \_\_\_\_\_ (Business)

**Medical History**

Date of participant's last Tetanus Vaccine (Within past 10 years) \_\_\_\_\_

List any special dietary needs that you have: \_\_\_\_\_

List any allergies you have, including reactions to insect bites, food allergies, and reactions or allergies to bug spray, sunscreen or other topical products:

\_\_\_\_\_

Have any of these allergies resulted in anaphylaxis?  Yes  No

If yes, will you be bringing an epinephrine injector to the Cleveland Metroparks program?  Yes  No

If yes, do you authorize Cleveland Metroparks staff to use your epinephrine injector (and, if necessary, Benadryl) if you are suffering from anaphylaxis and are unable to self-administer the epinephrine?

Yes  No



Are you taking any medication (oral or topical prescription or nonprescription)?  Yes  No

If yes, please list:

Medication/Dosage	Reason/Ailment
_____	_____
_____	_____

Do you require a special accommodation from Cleveland Metroparks for any reason in order to participate in the program?  Yes  No

If so, please describe the accommodation requested:

\_\_\_\_\_

List any other history of medical problems or special circumstances Cleveland Metroparks should be aware of: \_\_\_\_\_

\_\_\_\_\_

**Medical Insurance Company:** \_\_\_\_\_

**Physician:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Dentist:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Authorization, Signature and Consent to Treat**

In the event of injury or illness, I authorize on behalf of myself Cleveland Metroparks to provide first aid and/or medical treatment to me or to obtain first aid and/or medical treatment at the nearest and most adequate facility of Cleveland Metroparks' choice.

This medical treatment authorization form is completed and signed of my own free will and authorizes medical treatment for myself.

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date





**CLEVELAND METROPARKS/ CLEVELAND METROPARKS ZOO  
LIABILITY WAIVER (ADULT ATTENDEE)**

**Information**

Name of Participant: \_\_\_\_\_ Birth date: \_\_\_/\_\_\_/\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Business)

Email: \_\_\_\_\_

Name of Activity/Program: SCOUT NIGHT OVERNIGHT PROGRAM

Date(s) of activity: \_\_\_\_\_

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**Waiver of Liability and Signature**

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\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**CLEVELAND METROPARKS/ CLEVELAND METROPARKS ZOO  
MEDIA WAIVER (ADULT ATTENDEE)**

*(This form must be completed and returned to the program administrator before any program participation)*

Participant's Name \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address \_\_\_\_\_  
Phone #: \_\_\_\_\_ (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Business)  
Name of Group/School (if applicable) \_\_\_\_\_

Name of Activity/Program SCOUT NIGHT OVERNIGHT PROGRAM  
Date(s) of Program: \_\_\_\_\_

**PLEASE READ CAREFULLY**

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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.

- I AGREE (please sign below)
- I DISAGREE (please sign below)

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date