

Child's Name _____

LEAVE NO SPACE BLANK
REQUIRED for every participant
Camps & Programs

WAIVER AND MEDICAL FORMS

Program Attending _____

Child's Name _____ Birth Date _____

School _____ Grade _____

Address _____

Telephone _____

Guardian 1 _____ Daytime Phone _____ Other _____

Guardian 2 _____ Daytime Phone _____ Other _____

Other Name _____ Daytime Phone _____

Name of relative or childcare provider _____ Telephone _____

Address _____ Relationship _____

Authorization for Pick-Up

In the event that I cannot drop off or pick up my child for this program, I authorize the following persons to do so (please advise these individuals that a photo ID will be required before CMNH staff will release your child):

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

Signature of Guardian _____ Date: _____

Learning Style

Please specify anything which would help us better understand your child's learning style or personality:

Pre-care and Aftercare

There is NO Pre-care or Aftercare for programs. Any child remaining more than 30 minutes past end of program will incur an additional \$50 for the day. The \$50 will be charged to the credit card used to register for program.

Waiver & Release

As part of the consideration tendered for my child being permitted to participate in activities at and/or administered by the Cleveland Museum of Natural History, I agree (for and on behalf of my child) to, and do hereby waive any and all claims against, and agree to fully release, hold harmless, and indemnify the Cleveland Museum of Natural History, its officers, employees, agents, and volunteers from any and all claims related to any illness, injury, including loss of life or disability, property damage, or loss of any other description which my child may sustain out of or in any way associated with, my child's participation in said event.

I give my permission for the Cleveland Museum of Natural History to use images, likeness, and/or sound recordings of my child for purposes solely related to activities at the Cleveland Museum of Natural History.

Signature of Guardian _____ Date: _____

Behavior Agreement

I, on behalf of myself and my minor child, agree to follow the rules of the Cleveland Museum of Natural History and its staff during my child's participation in this program. I understand that any child exhibiting chronic insubordination, behavior that may cause harm to themselves, other participants, or staff will be asked to leave the program without a refund. These behaviors include, but are not limited to, hitting, kicking, biting, sexual harassment and/or possessing weapons or illegal substances.

Signature of Guardian _____ Date: _____

Authorization to Share Records

I understand that minimum necessary information will be shared with Museum staff personnel. And, I agree to the release of any records necessary for emergency treatment.

Signature of Guardian _____ Date: _____

Please continue on other side

MEDICAL TREATMENT RELEASE

In the event reasonable attempts to contact me at above phone number or the other guardians at the above phone number have not been successful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above named doctors or above named preferred dentist, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to the above preferred hospital or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Doctor _____	Telephone _____
Dentist _____	Telephone _____
Medical Specialist _____	Telephone _____
Local Hospital _____	Telephone _____

Facts concerning the child's medical history and/or any physical impairment to which a physician should be alerted:

Medications being taken:

Wear glasses? YES NO Wear contacts? YES NO Uses an inhaler? YES NO
 Has an Epi-Pen for allergic reactions? YES NO

Signature of Parent/Guardian _____ Date: _____

IF YOUR CHILD USES AN EPI-PEN OR INHALER PLEASE FILL OUT THE ALLERGY AND ASTHMA INFORMATION SECTION BELOW.

FOOD ALLERGY and ASTHMA Information (only if applicable)

Allergies: _____

What are the symptoms and treatments:

Is child Asthmatic? YES NO Does child carry inhaler? YES NO

Current medications for Asthma control: _____

Is student capable and responsible for self-administering this medication? YES NO

EMERGENCY CALLS

I understand that if symptoms are not relieved by steps taken above and indicate the need for emergency care, Museum staff will activate the 911 emergency system

1. Call 911. State that an allergic reaction has been treated, and additional Epinephrine may be needed.

2. Dr. _____ Phone _____

3. Emergency Contact: _____ Phone _____

Guardian Signature _____ Date _____

Please complete and return form to: **Cleveland Museum of Natural History**
Attn: Education Division
1 Wade Oval Drive
Cleveland, Ohio 44106