

Medical, Health, and Photo Registration Form

CHILDREN'S MARITIME FOUNDATION

Name (last, first): _____

PARTICIPANT'S NAME (Please print)	AGE	BIRTHDATE / /	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
ADDRESS (include city and zip)	DAY PHONE () -		
	EVENING PHONE () -		
NAMES OF CUSTODIAL PARENT/GUARDIAN(s)		E-MAIL	

EMERGENCY CONTACT NAME (1)	DAY PHONE () -	EVENING PHONE () -	CELL PHONE () -
EMERGENCY CONTACT NAME (2)	DAY PHONE () -	EVENING PHONE () -	CELL PHONE () -

HEALTH HISTORY: The following information must be filled in by the parent/guardian. Please complete the form in detail so that we can be aware of your child's needs.

PLEASE NOTE ANY HEALTH PROBLEMS YOUR CHILD MAY HAVE EXPERIENCED IN THE MONTH PRIOR TO ATTENDING:

Has/does the participant:	YES	NO		YES	NO
Ever have bleeding / clotting disorders?	<input type="checkbox"/>	<input type="checkbox"/>	Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Have convulsions?	<input type="checkbox"/>	<input type="checkbox"/>	Have hay fever?	<input type="checkbox"/>	<input type="checkbox"/>
Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	Ever had poison oak?	<input type="checkbox"/>	<input type="checkbox"/>
Ever have chronic ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	Ever been allergic to penicillin?	<input type="checkbox"/>	<input type="checkbox"/>
Have heart defects / hypertension?	<input type="checkbox"/>	<input type="checkbox"/>	Ever been allergic to iodine?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had psychiatric treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Ever been allergic to latex?	<input type="checkbox"/>	<input type="checkbox"/>
Have epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	Ever been allergic to bee stings?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had seasickness?	<input type="checkbox"/>	<input type="checkbox"/>	Any physical impairment?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>	Wear contact lenses or glasses?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had joint problems?	<input type="checkbox"/>	<input type="checkbox"/>	Other (Please list)	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE EXPLAIN ANY "YES" ITEMS CHECKED:

EXPLAIN ANY ACTIVITY RESTRICTIONS:

ANY SPECIAL NEEDS YOU WOULD LIKE YOUR CHILD'S COUNSELOR TO KNOW ABOUT:

MEDICATION Please list **ALL** medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person takes NO medications on a routine basis.

This person takes medications as follows:

Med #1 _____ Dosage: _____ Specific time taken each day: _____

Med #2 _____ Dosage: _____ Specific time taken each day: _____

Med #3 _____ Dosage: _____ Specific time taken each day: _____

Does the participant carry: An Inhaler? Yes No An EpiPen? Yes No

Non- Prescription Medications: I authorize the following medications to be administered as needed:

Tylenol <input type="checkbox"/> Yes <input type="checkbox"/> No	Benadryl <input type="checkbox"/> Yes <input type="checkbox"/> No	Tums <input type="checkbox"/> Yes <input type="checkbox"/> No	Sudafed <input type="checkbox"/> Yes <input type="checkbox"/> No
Chloraseptic <input type="checkbox"/> Yes <input type="checkbox"/> No	Cough Drops <input type="checkbox"/> Yes <input type="checkbox"/> No	Ibuprofen <input type="checkbox"/> Yes <input type="checkbox"/> No	Calamine Lotion <input type="checkbox"/> Yes <input type="checkbox"/> No

School/Organization _____

Date: _____



PARTICIPANT'S NAME (Please print) _____

HEALTH QUESTIONNAIRE:

DATE OF LAST COMPLETE PHYSICAL EXAMINATION:

LIST ANY ALLERGIES (Food, Medications, other):

DIETARY RESTRICTIONS EXPLAIN: Vegetarian Vegan Nut Allergy I eat: Chicken Pork Beef Kosher

NAME OF PHYSICIAN:

PHYSICIAN'S TELEPHONE:

DOES PARTICIPANT CARRY ANY MEDICAL INSURANCE?

CARRIER:

ADDRESS:

(____)____-____

Yes No

POLICY NO:

WAIVER: Please review, initial and check one box in each of the following sections. When complete, please sign at the **X** at the end.

A. AUTHORIZATION FOR TREATMENT:

As parent/guardian, I certify that my child is in excellent health and has no physical, mental or emotional problems which are likely to prevent participation in strenuous physical activity. I give permission for participant to be medically treated for illness occurring or injury sustained during such participation. I certify that I have completed the Health History and Health Questionnaire fully and accurately, and accept full responsibility for any errors or omissions. I have read the foregoing and fully understand it.

I agree I disagree Initial: _____

B. PHOTOGRAPH/INTERVIEW AUTHORIZATION: I agree that any photographs and videos taken by any Children's Maritime Foundation (CMF) personnel shall be the property of CMF, and may be used by CMF, at its discretion, for any publicity, marketing and/or advertising purposes, and I hereby consent to and authorize such use without restriction. I also give permission for my child to be interviewed about CMF by the news media.

I agree I disagree Initial: _____

C. WAIVER OF LIABILITY INDEMNIFICATION AND HOLD HARMLESS AGREEMENT

1. In consideration of being allowed to participate I hereby RELEASE, WAIVE, DISCHARGE AND COVENANT NOT TO SUE THE CHILDREN'S MARITIME FOUNDATION, THEIR OFFICERS AND EMPLOYEES (hereinafter collectively referred to as the "RELEASEES") from any and all liabilities, claims, demands, actions and causes of action whatsoever arising out of or related to any loss, damage, or injury, including death, that may be sustained by minor, or to any property belonging to me or minor, WHETHER CAUSED BY THE NEGLIGENCE OF THE RELEASEES, or otherwise, while participating in such activity, or while in, on or upon the premises where the activity is being conducted.

2. I am fully aware of risks and hazards connected with the activity of CHILDREN'S MARITIME FOUNDATION, the risk of which include but are not limited to risks associated with water activities, hiking, tide pooling, kayaking and snorkeling activities and transportation to and from sites, and I hereby elect to voluntarily participate in said activity, and to enter the above-named premises and engage in such activity knowing that the activity may be hazardous to participant and my property. I VOLUNTARILY ASSUME FULL RESPONSIBILITY FOR ANY RISKS OF LOSS, PROPERTY DAMAGE OR PERSONAL INJURY, INCLUDING DEATH, that may be sustained by participant, or any loss or damage to property owned by me, as a result of being engaged in such an activity, WHETHER CAUSED BY THE NEGLIGENCE OF RELEASEES or otherwise.

3. I further hereby AGREE TO INDEMNIFY AND HOLD HARMLESS the RELEASEES from any loss, liability, damage or costs, including court cost and attorney's fees, that they may incur due to participation in said activity, WHETHER CAUSED BY NEGLIGENCE OF RELEASEES or otherwise.

4. It is my express intent that this Release, and Hold Harmless Agreement shall bind the members of my family and spouse, if I am alive, and my heirs, assigns and personal representative, if I am deceased, and shall be deemed as a RELEASE, WAIVER, DISCHARGE AND COVENANT NOT TO SUE the above-named RELEASEES. I hereby further agree that this Waiver and Liability and Hold Harmless Agreement shall be construed in accordance with the laws of the State of California.

IN SIGNING THIS RELEASE, I ACKNOWLEDGE AND REPRESENT THAT I have read the foregoing Waiver of Liability Indemnification and Hold Harmless Agreement, understand it and sign it voluntarily as my own free act and deed; no oral representations, statements, or inducements, apart from the foregoing written agreement, have been made. As parent/guardian, I certify that he/she is in excellent health and has no physical, mental or emotional problems which are likely to prevent participation in strenuous physical activity. I give permission for participant to be medically treated for illness occurring or injury sustained during such participation and certify that he/she is covered by medical insurance.

I agree I disagree Initial: _____

X

Signature of Parent / Guardian

Date