



CLEVELAND METROPARKS ZOO

Cleveland Metroparks Zoo Volunteer WAIVER AND RELEASE

For those under the age of eighteen (18) years

(This form must be completed and returned to the volunteer coordinator before any volunteer activity)

Participant's Name _____ Birth date _____

Parent/Guardian Name _____

Address _____

Phone _____ (Home) _____ (Business)

PLEASE READ CAREFULLY

As part of the consideration tendered for my child/ward being permitted to participate in volunteer activities on _____ (date), I agree (for and on behalf of myself and my child/ward) 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, and volunteers from any and all claims related to any illness, injury, including loss of life, property damage, or loss of any other description which I (or my child/ward) may sustain arising out of , or in any way associated with, my child/ward's participation in volunteer activities.

I understand and agree that the child/ward will receive no workers' compensation or liability insurance coverage from Cleveland Metroparks. I further understand that if my child/ward is under age 10, that I will be present to supervise my child/ward during the volunteer activity.

It is agreed that this document shall be interpreted according to the laws of the State of Ohio.

(The custodial parent must sign. If the minor lives with both parents, **both** must sign.)

Parent Date

Parent Date

MEDICAL TREATMENT INFORMATION MUST BE COMPLETED ON REVERSE SIDE



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Cleveland Metroparks Zoo Volunteer Medical Treatment Release

For those under the age of eighteen (18) years

To Whom It May Concern:

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

Name of volunteer: _____

Parent(s) name(s): _____

Date(s) of activity: _____

Emergency Contact:

Name _____

Address _____

City, State, Zip _____

Relationship _____ Phone # _____

Medical History:

Special Dietary Needs _____

Does your child/ward have any allergies, including reactions to insect bites/stings and food? (List)

Is your child/ward taking any medication? _____

Medication

Reason/Ailment

Any history of medical problems or special circumstances we should be aware of?

Medical Ins. Co. _____ Physician/Ph # _____

This release is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances for myself or, in my absence, for the minor child/ward listed.

Signed _____ Phone _____
(by adult participant or guardian of minor child/ward)

Address _____ City/Zip _____