



**EDUCATION DIVISION
NIGHT TRACKS OVERNIGHT
WAIVER AND RELEASE FORM**

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

Participant's Name _____ Birth Date _____
Must be at least six years old.

Parent/Guardian Name *(if applicable)* _____

Address _____

Phone _____ *(Home)* _____ *(Business)*

Name of Group _____

Date of Program _____

PLEASE READ CAREFULLY

(Provisions in parentheses apply if the waiver is signed for a minor or ward)

PHOTO RELEASE: I give Cleveland Metroparks permission to publish in print, electronic, or video format the likeness or image of my child. I release all claims against Cleveland Metroparks with respect to copyright ownership and publication including any claim for compensation related to use of the materials. I understand cautionary steps will be taken to provide minimum identifying information and no specific mailing address or phone number will be used.

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

A part of the consideration tendered for my (and my child/ward) being permitted to participate in an overnight program on _____, 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 (or my child/ward's) participation in

_____.

(If the participant is a minor, the parent(s)/guardian(s) must sign)

Participant/Parent/Guardian Date

MEDICAL TREATMENT INFORMATION MUST BE COMPLETED ON REVERSE SIDE

CLEVELAND METROPARKS ZOO
Night Tracks Overnight
Medical Treatment Release

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 Participant: _____

Must be at least six years old.

Dates when release is effective: _____

(program dates)

Emergency Contact:

Name _____

Address _____

City, State, Zip _____

Relationship _____ Phone # _____

Medical History:

Special Dietary Needs _____

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

Are you (or 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 _____