

IslandWood Release Form (Children under 18 years old)
PARENT OR GUARDIAN: PLEASE COMPLETE BOTH SIDES OF THIS FORM IN INK.

CHILD'S NAME _____
School/Group: _____ Program Dates: _____
Teacher's Name _____
Child's Age: _____ Grade: ____ Birth Date: _____ Gender: Male __ Female __ or _____
Parent/Guardian Name: _____ Day Phone: () _____
Address (include city and zip): _____
Evening Phone: () _____ Cell Phone: () _____ Email: _____
EMERGENCY CONTACT:
Name: _____ Day Phone: (____) _____
Evening Phone: (____) _____ Cell: (____) _____ E-mail: _____

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING

ACKNOWLEDGEMENT AND RELEASE AUTHORIZATION FOR MEDICAL TREATMENT:

I am familiar with the program for which the child is registering. I understand that this program involves activities of a physical nature that will take place in an outdoor environment and may include hiking on trails and rough terrain and in the vicinity of bodies of water, overnight camping and walking on high bridges and canopy walkways. I further understand that there are risks associated with these kinds of activities.

As a condition of participation in this program and/or the use of IslandWood equipment and/or facilities, I agree that I will be fully responsible for any and all personal injuries, property damage, loss of personal property, or any other loss that may result from my child's participation, and I agree not to hold IslandWood responsible, and their respective agents and employees, to the fullest extent permitted by law, for any damages, liabilities or expenses that result from participation in this program and/or the use by the participant of any IslandWood facilities and /or equipment.

If my child is taking any medication, I understand that IslandWood will not be responsible for administering or dispensing such medication, and that I will be required to make any necessary arrangements for the administering of such medication through the participant's school. I hereby give permission to personnel of ISLANDWOOD to authorize any x-rays, tests, procedures, anesthetic, surgery or treatment on behalf of, and to provide or arrange for any transportation of, my child as may be required in the event of an emergency. If I, or the emergency contacts designated previously, cannot be contacted, I hereby give permission to a licensed physician, or other qualified health care provider as may be appropriate, to administer such treatment to my child, the participant, as may be necessary under the circumstances, including the hospitalization of my child.

I certify that I have completed the Health History and Health Questionnaire on the back of this form fully and accurately and accept full responsibility for any errors or omissions.

MEDIA/ARTWORK AUTHORIZATION: I agree that any photographs or digital images taken by IslandWood personnel of my child as a program participant, and copies of artwork made by my child while an IslandWood program participant, shall be the property of IslandWood, and may be used by IslandWood, at its discretion, for any publicity, education, marketing and/or advertising purposes and I hereby consent to and authorize such use without restriction.

We may use your information to contact you about IslandWood. If you do not wish to receive any further correspondence, please let us know at info@islandood.org.

I HAVE READ THE AGREEMENT, FULLY UNDERSTAND IT, AND GRANT PERMISSION FOR MY CHILD TO PARTICIPATE IN THE PROGRAM IDENTIFIED ABOVE.

Signature of Parent or Legal Guardian: _____ Date: _____

Print Name & Relationship to Child: _____

BEFORE RETURNING THIS FORM TO YOUR CHILD'S SCHOOL,
BE SURE TO COMPLETE THE MEDICAL/DIETARY QUESTIONS ON REVERSE!!!

<p>Race/Ethnicity/Origin To help support our mission to equitably serve all children, please circle or write in all categories that describe your child:</p> <p>Hispanic, Latino, or Spanish origin Black or African American Asian or Indian American Indian or Alaska Native Middle Eastern or North African Native Hawaiian or Other Pacific Islander White or Caucasian</p> <p>_____</p> <p>_____</p> <p>**Note: We will only use this information as part of our evaluation process. Specific information identifying your child will not be shared with any outside person or organization.</p>	<p>Medications</p> <p>Is your child taking any medications? ___ Yes * ___ No</p> <p>If yes, please list:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>*Please be sure to notify your child's teacher, submit any required paperwork, and provide the school with the necessary supply of your child's medication before the trip.</p>
<p>Food Preferences</p> <p>If your child has any food requests (for example, doesn't eat pork, avoids hard or sticky foods due to braces, dislikes cheese, etc.), please note them here. The below requests are NOT food allergies. Allergies must be noted in the box to the right.</p> <p>_____</p> <p>_____</p> <p>We are able to accommodate most food requests if we have advance notice.</p>	<p>Allergies</p> <p>Has your child been diagnosed with any possible life-threatening allergies? If yes, list the allergen(s):</p> <p>_____</p> <p>_____</p> <p>If you checked "Yes" your child must have a School Health Plan on file at school OR you must submit a doctor's Food Allergy Action Plan before your child may attend.</p> <p>Has your child been prescribed epinephrine?</p> <p>----- Yes ----- No</p>
<p>Miscellaneous</p> <p>Is there anything else that you believe it is important that we know in regard to your child's participation in this program? If so, please describe:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Health Care</p> <p>Name of physician: _____</p> <p>Physician's telephone: _____</p> <p>Is child covered by any medical insurance: ___ yes ___ no If so:</p> <p>Carrier: _____</p>

*****Please read and sign the front of this page.*****