Cleveland Sight Center

Name of Participant _____

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____

Email Address _____

I. Authorization to Attend Program, Activity, Event

I understand that my participation in programs, activities or events offered through Cleveland Sight Center is voluntary and at my own risk. I understand and assume the risks and hazards associated with such participation. I agree to release, forever discharge, and hold harmless the Cleveland Sight Center, its employees, agents, volunteers, administrators and trustees from any and all claims or causes of action that may be brought by me or by any other person, including all liability for personal injury, damage to personal property, or loss arising out of or related to my participation in programs, activities or events offered through Cleveland Sight Center and my transportation to and from such programs, activities and events by a Cleveland Sight Center volunteer or employee, to the fullest extent permitted by the law.

I also certify that I am legally authorized to register the individual named on this form for Cleveland Sight Center programs, activities or events.

_____ _____
Parent/Guardian or Adult Participant Signature Date

II. Medical and Emergency Information

Special Dietary Needs _____

Allergies _____

Special Medical Concerns or Problems (i.e. - diabetic, seizure disorder) _____

_____

Activity Restrictions: _____

Physician Name _____ Contact # _____

Emergency Contact:

Name _____ Relationship to Participant _____

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____

Authorization for Medical Care:
In the event of injury or illness, I give permission to Cleveland Sight Center to obtain first aid or medical treatment for myself or my child/ward. I give permission to the Health Care Professional(s) selected by Cleveland Sight Center to order x-rays, routine tests, and treatment related to the health of the above named participant for both routine health care and in emergency situations. I give my permission to the Health Care Professional(s) to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for the above named participant. I acknowledge that no guarantees have been made to me as to the effect of such treatment and that I am responsible for all reasonable charges in connection with the treatment rendered to the above named participant. I understand the information on this form may be shared with such Health Care Professionals. I give permission to photocopy this form. In addition, chosen Health Care Professional(s) have my permission to obtain a copy of the above named participant's health information from my health care providers.

_____ _____

Parent/Guardian or Adult Participant Signature Date

III. Consent for Photographs, Interviews, and/or Audio/Video Taping

I hereby consent to allow the above named participant to be photographed, interviewed, and/or recorded on film and/or audio/video tape for the purposes of distribution, sale, replay, and/or broadcast in any and all media, including without limitation print, radio, TV, cable, satellite, and/or internet, for the reason(s) stated below, by the Cleveland Sight Center (CSC) and/or the news media.

The use of the visual image of the above named participant, or information obtained from him or her in an interview or interviews is hereby permitted, provided that any news media presence and/or queries are approved by CSC's spokesperson. I understand that the image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein it appears. Additionally, I waive any right to royalties or other compensation arising out of or related to the use of the image or recording. I hereby release and hold harmless CSC and its officers, directors, employees, agents, volunteers, administrators, trustees, successors, and assigns from any and all liability for any damages or injury which might arise from the foregoing gathering and/or use of images of or information from the above named participant.

<u>Please indicate your consent for each area:</u>

_____ Health education purposes
_____ Release to news media for print or broadcast
_____ Cleveland Sight Center publications, brochures, videos, and training materials
_____ Other uses which may arise from time to time and deemed to be in the best interest of the mission of the Cleveland Sight Center

_____ _____

Parent/Guardian or Adult Participant Signature Date

<u>OR</u>

I do <u>not</u> consent to the gathering or use of images of or information from me or my minor child. Notwithstanding the foregoing, I understand that images of me and/or my minor child may be included in group photos of activities, but will never be identified.

_____ _____

Parent/Guardian or Adult Participant Signature Date