

RELEASE WAIVER



PLEASE USE A SEPARATE FORM FOR EACH PARTICIPANT.

Participant's Name: _____

Parent/Guardian Name (minors only): _____

Mailing Address: _____

Email: _____

Evening Phone: _____ Cell Phone: _____

PLEASE INITIAL THE FOLLOWING:

_____ I hereby release the Oregon Coast Aquarium officers and its employees from any claims which I might have for injuries or damage resulting from failure to follow instructions and cooperate as instructed or as a result of the risks and dangers involved in this activity.

_____ In the event that I / the child needs medical treatment, I hereby consent and authorize the accompanying representative of the Oregon Coast Aquarium to provide treatment. I agree to be responsible for the cost of any medical services and to indemnify the Oregon Coast Aquarium for such expenses.

_____ I hereby authorize Oregon Coast Aquarium personnel to photograph / video myself / the child for the purposes of education and promotion of Aquarium programs. I understand that these images may be used in a variety of ways, including videos, publications and websites. (By not initialing, you REVOKE consent.)

_____ I / the child do not have any physical or mental conditions which would restrict or prevent me / the child from participating in any scheduled activity, or which would increase the risk of harm with the exceptions listed on the medical form.

NON-DISCRIMINATION POLICY: The Oregon Coast Aquarium is proud of our diverse and inclusive programs. Consistent with our corporate non-discrimination policy and applicable laws, OCAq programs are open to everyone regardless of race, color, gender, national origin, age, religion, creed, disability, veteran's status, sexual orientation, gender identity or gender expression.

Signature (parent must sign for minors): _____

Printed Name: _____ Date: _____

Have questions or want additional information?

Contact 541-283-1148, or email sleepinthedeep@aquarium.org

PERSONAL & MEDICAL INFORMATION



PLEASE USE A SEPARATE FORM FOR EACH PARTICIPANT. THIS FORM IS CONFIDENTIAL.

Participant's Name: _____ DOB: _____

Parent/Guardian Name (minors only): _____

EMERGENCY CONTACTS

In case of emergency, please list the name and phone number of a second party who could respond.

Name: _____ Phone: _____ Relationship: _____

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MEDICAL INFORMATION

Please list any allergies, medical / behavioral issues, special needs etc. that our staff should be aware of or that may require special accommodations:

MEDICAL POLICY

In the case of medical emergency, it is Oregon Coast Aquarium policy to contact 911 immediately. If not present, parents and/or guardians will be contacted after emergency services have been activated. Aquarium staff are certified in CPR and Basic First Aid, but will not treat any serious medical condition nor administer medications of any kind. All information released by a parent and/or guardian on this form is considered confidential and will not be released to any third party.

Signature (parent must sign for minors): _____

Printed Name: _____ Date: _____

Have questions or want additional information?

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