



Waiver of Liability Form

School/Organization _____	Field Trip Date(s) _____	Teacher Name (if applicable) _____
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Please print the following information:

Participant's first, middle, last name _____	Date of birth (mm/dd/yy) _____	Gender M F	Zip code _____
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Identify participant's ethnicity (check all that apply):

- | | | | |
|--------------------------------|------------------------------------|--|---|
| <input type="checkbox"/> Asian | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Latino | <input type="checkbox"/> Pacific Islander |
| <input type="checkbox"/> Black | <input type="checkbox"/> Hawaiian | <input type="checkbox"/> Native American | <input type="checkbox"/> Other _____ |

Age category (check all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> Newborn - 2 years old | <input type="checkbox"/> Grade (K-12) _____ | <input type="checkbox"/> Enrolled in College/University |
| <input type="checkbox"/> Preschool | <input type="checkbox"/> Educator | <input type="checkbox"/> Adult/Parent |

EMERGENCY CONTACT

Name of primary emergency contact _____	Relationship to participant _____	Cell/Preferred phone _____
Name of secondary emergency contact _____	Relationship to participant _____	Cell/Preferred phone _____

MEDICAL INFORMATION

Hospital/Clinic preference _____	
Physician's name _____	Phone number _____
Insurance company _____	Policy number _____
Allergies/Special health considerations _____	
Medication(s) taken regularly _____	

➔ I do ____/do not ____ (initial one) give permission for Papahana Kuaola to use photographs and video recordings taken of myself, my child(ren), and/or minors in my care on the specified field trip date(s) for its non-profit work.

AUTHORIZATION

I give permission for myself, my child(ren), and/or minors in my care to participate in programming on the specified field trip date(s). I understand and acknowledge that participation involves inherent risks of injury. I release the landowner(s), Papahana Kuaola, its staff, and its Board of Directors from liability in case of an accident during the program, as long as normal safety procedures have been followed. I authorize all medical and surgical treatment as may be performed or prescribed by the attending physician and/or paramedics. I waive my rights to informed consent of treatment, only in the event that I or emergency contacts (listed above) cannot be reached. My signature below indicates that I have read, understood, and freely signed this form.

Parent/Guardian or Adult Participant's PRINTED NAME and SIGNATURE _____	DATE _____
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