



Five Rivers MetroParks Confidential Participant Risk/Release Form

Five Rivers MetroParks • 1375 E. Siebenthaler Avenue • Dayton OH 45414 • 937-275-PARK

Adventure programs are available to anyone. However, not everyone is physically or emotionally capable of performing well in these situations. Outdoor recreation participants may find themselves not only in a physically demanding activity but also in one that has inherent natural dangers, such as lightning, moving water, rock falls, etc. People are seriously injured and die every year from participating in outdoor recreation activities.

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

E-MAIL _____

PHONE DAY _____ PHONE EVE _____

AGE 0-17 18-35 36-45 46-55 56-65 66-74 75 +

Risk & Release Waiver PLEASE READ CAREFULLY

As part of the consideration tendered for myself (or my child/ward) being permitted to participate in Five Rivers MetroParks programs, 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 Five Rivers MetroParks, 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 description which I (or my child/ward) may sustain arising out of, or in any way associated with my (or my child's/ward's) participation in Five Rivers' MetroParks Five Rivers Outdoor program.

Consent to Treat:

In the event of injury or illness, I authorize (on behalf of myself or my child/ward) Five Rivers MetroParks to obtain first aid and/or medical treatment at the nearest and most adequate facility of Five Rivers MetroParks' choice. This release is completed and signed of my own free will and with the sole purpose of authorizing medical treatment under emergency circumstances for myself, or in my absence, for the minor child/ward listed.

Photo Release:

I authorize Five Rivers MetroParks to publish, in print, electronic, or video format, the likeness or image of myself or my child/ward, without limitation.

SIGNATURE: _____ DATE: _____
(If participant is a minor, the parent(s)/guardian(s) must sign.)
PRINT NAME: _____ Relationship to participant if under 18: _____

In case of emergency contact:

NAME _____ PHONE (DAY) _____ PHONE (EVE) _____

NAME _____ PHONE (DAY) _____ PHONE (EVE) _____



Five Rivers MetroParks Confidential Medical Information Form

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PART I: AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I am aware of my general condition and affirm that I am fit to participate in any activities required for participation in this program. I will fully disclose any relevant medical information on this form and to Five Rivers MetroParks Outdoor Recreation staff, and will engage in all prescribed activities except for those noted by me and/or by my examining physician. In the event I am rendered unable to communicate by an emergency or accident, I authorize and request such medical and surgical services as may be necessary, and further agree to accept financial responsibility for same.

PART II: MEDICAL INFORMATION

Your Five Rivers MetroParks Outdoor Recreation program may involve strenuous physical activity. If you have questions regarding your health and participation, please consult your personal physician. We ask for the following information to be aware of potential problems and to help you safely enjoy your time with us. Attach additional pages as needed.

HEIGHT____WEIGHT____DATE OF LAST TETANUS SHOT_____

DO YOU HAVE/EXPERIENCE? (PLEASE CHECK THE APPROPRIATE COLUMN)

Yes /No

___/___ Asthma--If yes, what triggers it? _____

___/___ Diabetes or difficulty maintaining blood sugar

___/___ High Blood Pressure

___/___ Heart Disease

___/___ Are you pregnant?

___/___ Dislocations--If yes, which joint(s)? _____

___/___ Back Problems

___/___ Seizures--If yes, when was your last? ___/___/___ How often do they occur? _____

___/___ Are you currently taking medication? If yes, what type? _____

Do you suffer from Dizziness or Car Sickness? If yes, please explain _____

Please list any side effects (fatigue, sensitivity to sun, etc.): _____

___ ___ Are you allergic to any medications, insect bites/sting, and/or foods? Please list: _____

If yes, what happens & do you carry medication? _____

___ ___ Has a physician or health care provider recently restricted your physical activity?--If yes explain: _____

Please Circle your swimming ability: Can't Swim Very Weak Weak Moderate Strong Very Strong

Do you have any other medical issues that would be important for us to know? Yes /No

If yes, please explain:

Please include detail about any medical information that you checked YES for or other information that may be relevant to staff, EMS or hospital staff:

ANYONE WITH SEVERE ALLERGIES TO FOOD, PLANTS OR INSECTS MUST INFORM FRMP STAFF, BRING THEIR OWN MEDICATION, AND BE ABLE TO SELF-ADMINISTER IT!

SIGNATURE: _____ DATE: _____

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

PRINT NAME: _____ Relationship to participant if under 18: _____