Age of Sail Overnight Program

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Participant Emergency Contact Information | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
|  | | | | |  |  | | | | | M | | F |
| Child’s Name | | | | |  | Date of Birth | | | | | Sex | | |
|  | | | | |  |  | | | | | | | |
| Parent’s/Guardian’s Name | | | | |  | Parent’s/Guardian’s Name | | | | | | | |
|  | |  |  | |  |  | |  |  | | | | |
| Home Phone | |  | Work Phone | |  | Home Phone | |  | Work Phone | | | | |
|  | | | | |  |  | | | | | | | |
| Address | | | | |  | Address | | | | | | | |
|  | | | | |  |  | | | | | | | |
| City, ST ZIP Code | | | | |  | City, ST ZIP Code | | | | | | | |
|  | | | | |  |  | | | | | | | |
| Alternative Emergency Contact | | | |  | | | Insurance Information | | | | | | |
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|  | | | | |  |  | | | | | | | |
| Additional Emergency Contact | | | | |  | Name of Family Physician | | | | | | | |
|  | |  |  | |  |  | |  |  | | | | |
| Home Phone | |  | Work Phone | |  | Physician Phone | |  | Physician Office/Hospital | | | | |
|  | | | | |  |  | | | | | | | |
| Address | | | | |  | Insurance Provider | | | | | | | |
|  | | | | |  |  | | | | | | | |
| City, ST ZIP Code | | | | |  | Insurance ID # Group # | | | | | | | |
|  | | | | |  |  | | | | | | | |
| Medical Information | | | | | | | | | | | | | |
|  | | | | | | | | | |  | |  | |
| Is your child currently taking any prescription medications? (list below)\*……………..  \*If **YES** please fill out “Administration of Medication” form for EACH medication that will be taken during the program | | | | | | | | | | **YES** | | **NO** | |
| 1) |  | | | | | | | | | | | | |
| 2) |  | | | | | | | | | | | | |
| 3) |  | | | | | | | | | | | | |
| Does your child have any allergies? (list below)……………………………………….. | | | | | | | | | | **YES** | | **NO** | |
| \*Does your child have an EPI pen? ……………………………………………. | | | | | | | | | | **YES** | | **NO** | |
| 1) |  | | | | | | | | | | | | |
| 2) |  | | | | | | | | | | | | |
| 3) |  | | | | | | | | | | | | |
| Is your child on a special diet? ………………………………………………………… | | | | | | | | | | **YES** | | **NO** | |
| Explain: | | | | | | | | | | | | | |
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|  | | | | | | | | | | | | | |
| Has your child recently been ill or exposed to communicable disease? ……………….. | | | | | | | | | | **YES** | | **NO** | |
| Is your child subject to **Homesickness / Sleepwalking / Bedwetting** (circle) ……….. | | | | | | | | | | **YES** | | **NO** | |
| Are there any other issues concerning your child that we should know about? ……….. | | | | | | | | | | **YES** | | **NO** | |
| Explain: | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
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| **Non-Prescription Medication**  In the event of unforeseen circumstances, do you authorize the Age of Sail staff to give your child common remedies such as Children’s Tylenol, cough medicine, etc.?   |  |  | | --- | --- | | **YES** | **NO** |   If you wish for your child to receive non-prescription medications or vitamins, please fill out an “Administration of Medication” form for each medication / supplement.  **AUTHORIZATION AND CONSENT FOR STUDENT TREATMENT**  1. Parent(s) will be notified immediately when a child becomes injured or seriously ill, and aid will be given according to the Parent(s) wishes. Arrangements will be made with the parent(s) to pick up their child if desired. A child will not be released during the Age of Sail program to anyone other than the parent or guardian except on written or verbal request by the parent or guardian.  2. I/WE, as parent(s) or guardian(s) of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ do hereby authorize the Age of Sail staff, as agents, for the undersigned to consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered under the general or specific supervision of any physician and/or surgeon licensed under the provisions of the California Medical or Dental Practice Act on the Medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or said hospital.  It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of the aforesaid agents to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable. This authorization is given pursuant to the provisions of section 25.8 of the Civil Code of California. This authorization shall remain in effect until \_\_\_\_\_\_\_(date program ends) unless revoked sooner in writing delivered to said agents.   |  |  |  | | --- | --- | --- | | Signature of Parent(s) or Legal Guardian(s) |  | Date | |  |  |  | |  |  |  |   **Please Note:**   |  | | --- | | **If you do not wish to grant authorization or consent as outlined above, please sign here and let us know in writing what you want us to do in the event of a medical emergency**  Signature of Parent(s) or Legal Guardian(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_  Signature of Parent(s) or Legal Guardian(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |

Program Release

We request that all participants agree to the below provisions and sign below to acknowledge their agreement. A participant without an initialed participation agreement will not be allowed to participate in the program.

A. Participation Agreement

In consideration of myself or my child participating in the programs of the San Francisco Maritime National Park Association, I agree on behalf of myself and my child to assume all risks of injury and to waive all claims, actions, and damages against the Maritime Park Association. I further agree not to sue the Maritime Park Association, its officers, directors, employees, agents or assigns for any claims arising out of participation in the Maritime Park Association’s programs, the actions of the school district or youth group's employees, officers or agents, or the actions of the program participants.

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| --- | --- | --- |
|  |  |  |
| Participant’s Name |  |  |
|  |  |  |
| Signature of Parent or Legal Guardian |  | Date |

**B. Photo Release**

For the purposes of fund-raising and public awareness, the San Francisco Maritime National Park Association uses photographs and videos of the program in action. These materials may be published in print or made available on our website. Such publications are a very important part of our fundraising efforts. Your child's image may appear in such photos or videos taken by the adult chaperones or our official photographers. We are sensitive to privacy issues, and therefore specific names of participants and their school addresses will not be disclosed.

MEDIA RELEASE: I hereby give permission for San Francisco Maritime National Park Association staff and/or any person acting on their behalf and/or other participants to photograph my child and allow San Francisco Maritime National Park Association to use these pictures in the course of its operations, including publicizing its programs and raising funds. I release all publication rights to said media. (San Francisco Maritime National Park Association will not use student’s names or other identifying information.)

**OPT OUT SECTION:**To **OPT OUT**, please check the box below and sign:

**☐ I DO NOT give permission       Initials: \_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**

**C. San Francisco Maritime Opportunities**

SF Maritime offers a wide range of programs, events, and opportunities. Would you like to stay connected with us?

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_