

KEY PEN PARKS HOLD HARMLESS AGREEMENT

Current Year: _____ (This hold harmless form will cover participant with any current programs within this calendar year)

In consideration of Key Pen Parks granting the undersigned the opportunity of attending or participating in Key Pen Parks Recreation Programs is for the purpose of leisure enjoyment; and the undersigned recognizing the fact that no benefits are derived by Key Pen Parks by allowing the undersigned to attend or participate. I, the undersigned, hereby release and hold harmless Key Pen Parks, its elected officers, employees, contractors, volunteers, and agents from any and all liability claims, damages, costs, and expenses for both personal injury and/or property damage which may arise as a result of my, or my child's participation in the program. I agree to assume all risks associated with the program.

In case of emergency, and you are unable to contact me/us and/or you believe it is necessary to obtain the services of a doctor and/or hospital without first contacting me/us, I hereby authorize you and my doctor or hospital to immediately render all services and treatment deemed necessary at my/our expense.

PLEASE PRINT LEGIBLY

Participant: _____ Age: _____ Birth Date: ____/____/____

Address: _____ City: _____ State: _____
Zip: _____

Home Phone: (_____) _____ Work: (_____) _____

Signature of Parent/Guardian: _____ Email: _____

Yes No I give permission for my child's photo to be used for marketing purposes for Key Pen Parks.

MEDICAL HISTORY

Physician's Name _____ Date of Last Exam _____

Do you have or have you had any of the following. Please indicate with a check mark .

_____ Any Heart Problems	_____ High Blood Pressure*	_____ Diabetes
_____ Stroke	_____ Low Blood Pressure*	_____ Excessive Bleeding
_____ Anemia	_____ Circulatory Problems	_____ Hepatitis
_____ Nervous Problems	_____ Psychiatric Care	_____ Ulcer
_____ Malignancies	_____ Radiation Treatments	_____ Measles
_____ Mumps	_____ Rheumatic Fever	_____ Scarlet Fever
_____ Typhoid Fever	_____ Tuberculosis	_____ Allergies to Anesthetics
_____ Tonsillitis	_____ Sinus Problems	_____ Allergies to medications/ drugs
_____ Asthma	_____ Arthritis	_____ Allergies to: _____

*Blood Pressure: S ____ /D ____ / ____ Blood Type (if known) _____

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your treatment (including prescription medications). _____

Are there special precautions or needs staff should be aware? Yes _____ No _____

If yes, please indicate what precautions should be taken. _____

EMERGENCY CONTACT

Name Relationship

Phone (Day) Phone (Evening)