Georgia Department of Natural Resources Registration and Waiver Release Form

GEORGIA DEPARTMENT OF NATURAL RESOURCES
WILDLIFE RESOURCES DIVISION

Event: _____ Date: _____

I understand that there are risks of injury or death or damage to property involved in my participation in such an event, that it is my responsibility to insure the safety of the equipment used and to see that it is operated properly, and that the Georgia Department of Natural Resources (hereafter, Department), its staff and representatives, as well as the landowner, its officers and employees assume no responsibility for the condition of such equipment, its operations, or safety of the activities involved in this event. In consideration of the acceptance of this registration by the Department, I waive and release and hold harmless the Department, its staff and representatives as well as the landowner, its officers and employees from any and all claims of damages against the Department, its staff and representatives, as well as the landowner, its officers and employees for injury, or death or damage to property that may occur as a result of or in connection with this event and agree to pay, protect, indemnify and save against all liabilities, damages, costs, expenses, causes of action, suits, demands, judgments and claims of any nature whatsoever arising from, by reason of, or in connection with any injury or death of persons or damage to property arising from, by reason of or in connection with my participation in this event.

I further understand that such an event requires all participants to be in good health and without physical limitations and I certify that I am in good health and have no physical limitations.

Full Name_____

Street Address_____

City _____ State _____ Zip _____

Age ____ Phone: _____ E-Mail:_____

Please list any medical care or physical conditions that the event coordinators should be aware of (Examples: diabetic or special medications)._____

_____

_____

I have read this entire form, including the statement of good health, acceptance of risk and waive, release and indemnification provisions. All information I have given is accurate and correct.

Signature _____Date: _____

Photo/Film Release - Photographs/film may be used of me or my child in publications, including electronic publications, or in audiovisual presentations, promotional literature, advertising, or in other similar ways.

Signature_____ Date: _____

Charlie Elliott Wildlife Center

Participant Health Record and Emergency Information

Name (Last, First, Initial) **Birth Date**

Address **City/Town** **State** **Zip** **Phone** ( )

E-Mail Address (For CEWC use only) **Home Phone** ( )

School/Organization **Title** **Work Phone** ( )

Name of Alternate Emergency Contact **Relationship** **Home Phone** ( )

Address **City/Town** **State** **Zip** **Work Phone** ( )

INSURANCE INFORMATION, PLEASE COMPLETE THE FOLLOWING (Please provide copy of card):

Carrier **ID Number** **Group Number** ( )

Member Services Phone Number **Address** **City/Town** **State** **Zip**

HEALTH HISTORY: (Check those that apply)

TRAVEL OUTSIDE US in last 6 months:
- ☐ Yes
- ☐ No

If yes, have you had these symptoms?
- ☐ Nausea
- ☐ Fever
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Rash/Skin Irritation

ALLERGIES:
- ☐ Animals:_____
- ☐ Food: _____
- ☐ Hay Fever
- ☐ Insect Stings
- ☐ Medicine/Drugs:_____
- ☐ Plants:_____
- ☐ Pollen
- ☐ Other(specify):_____
- ☐_____
- ☐_____
- ☐_____
- ☐_____

CHRONIC or RECURRING ILLNESS:
- ☐ Ear Infections
- ☐ Heart Defect/Disease
- ☐ Seizures
- ☐ Bleeding Disorders
- ☐ Asthma
- ☐ Hypertension
- ☐ Diabetes
- ☐ Musculoskeletal Disorders
- ☐ Arthritis
- ☐ Sinusitis
- ☐ Other(specify):_____

APPLIANCES:
- ☐ Hearing Aid
- ☐ Orthopedic Braces
- ☐ Glasses
- ☐ Contact Lenses
- ☐ Dental Braces
- ☐ Pacemaker
- ☐ Retainer/Dentures
- ☐ EpiPen
- ☐ Inhaler
- ☐ Other(specify):_____
- ☐_____
- ☐_____
- ☐_____

DETAILS OF ANY CHECKED ITEMS ABOVE (i.e. allergic reactions to bee stings, food, or medications/drugs) _____

Have you had any serious injuries or surgeries in the past year? If so please let us know below:

:

:

Any known recent exposure to contagious disease(s) within the last 6 weeks? ☐ YES ☐ NO If YES, give details:

Special medical or dietary preferences to be followed (specify):

This Participant Health Record and Emergency Information is complete and accurate to my knowledge. I give permission to engage in all prescribed activities, except as noted by me. I give permission to receive routine healthcare, approved medications, and emergency medical and surgical treatment and to be hospitalized, if necessary. It is understood that every effort will be made to contact me or the person(s) noted above before taking this action.

SIGNATURE OF PARTICIPANT: **DATE:**

Name: _____ **Date:** _____

Are there any activities you should not participate in for medical reasons? ❒ NO ❒ YES If YES, please note which activities below:

_____

Do you have a disability? ❒ NO ❒ YES If YES, do you need an accommodation? ❒ NO ❒ YES If YES, attach a separate paper to explain.

MEDICATIONS: Are there any medications that you are currently taking?
IF SO, PLEASE LIST CURRENT MEDICATIONS BEING TAKEN

Medication	Reason for Taking	Dosage	Prescribed by Doctor?	Administering Directions	Taken with food?	Medications are administered during meal times. Please circle the time meds are taken.
						8:15 am 12:00 pm 5:00 pm 9:30 pm Other ___ am/pm
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HEALTH INFORMATION PRIVACY STATEMENT

The **Emergency Information** is for health care concerns at the specified event only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor of the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. The Emergency Information Record will be retained by Charlie Elliott Wildlife Center until it is destroyed. All forms/records with noted treatment will be retained for one year. Access to the information will be limited, but copies may be requested from CEWC, by the participant or their legal representative.

I have read the above procedures for handling the health form information and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

SIGNATURE:_____ **DATE:**_____

CEWC 08/17 AB