

HIDE AWAY at CAMERON LANE

RIDERS RELEASE FORM

Box, 162, Burlington CO 80807

Riders' Name _____ D.O.B. _____

Parent/Guardian _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

In the event emergency medical aid/treatment is required due to illness or injury while participating in program functions, I authorize Hide-Away at Cameron Lane (HACL) to:

1. Secure and retain medical treatment and transportation if needed.
2. Release student records upon request to authorized individual or agency involved in the medical emergency treatment.

This authorization includes x-ray, surgery, hospitalization, medication (including anesthesia), and any treatment procedure deemed "life saving" by the medical professional. This provision will be invoked only if the person listed below is unable to be reached.

Emergency contact _____ Phone _____

Physician's name _____ Phone _____

Allergies _____ Seizures _____

Medications _____

If parent/guardian/self does not consent to above emergency procedures, and wishes alternate action taken, please sign here: _____

I _____ DO I _____ Do not:

Consent to and authorize use and reproduction by HACL of any and all photographs and any other audio-visual materials taken of my child/ward/myself for promotional printed material, educational activities, and exhibitions or for any other use for the benefit of the program.

Signature _____