DELAWARE RIVER STEAMBOAT FLOATING CLASSROOM

PARENTAL PERMISSION FORM

THIS FORM MUST BE COMPLETED AND RETURNED TO THE TEACHER TO BRING TO THE BOAT TRIP.

TRIP DATE: ____________________ SCHOOL: ____________________________

PARTICIPANT'S NAME: _______________________________ AGE: ___ FEMALE___ MALE ___

PARENT OR GUARDIAN: ______________________________

WORK PHONE: ____________________ HOME AND/OR CELL PHONE: _____________________________

HOME ADDRESS: ____

Street City State ZIP

EMERGENCY CONTACT IF PARENT OR GUARDIAN IS UNAVAILABLE:

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WORK PHONE: ____________________ HOME AND/ OR CELL PHONE: _____________ _____________

LIABILITY WAIVER: I fully understand that participation in activities of the Delaware River Steamboat Floating Classroom (DRSFC) is entirely voluntary and that the DRSFC program involves boating with its attendant risks. I know and understand the risks involved in such activities, and that unanticipated events might arise. I hereby release DRSFC and its subcontractors from any liability for injury that might occur as a result of participation in these activities. I give permission for the named participant to participate in all such activities, except as noted below.

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PHOTO PERMISSION: I give permission to DRSFC and its subcontractors to have ownership of, unrestricted use of, and copyrights to any photographic and audio reproductions of the above named participants (me or my child) taken during participation in DRSFC activities, and release the DRSFC and its subcontractors from all claims and liability relating to said reproductions.

MEDICAL PERMISSION: I give permission authorizing DRSFC and subcontractor personnel to carry out emergency diagnostic and therapeutic procedures as may be necessary for above named participant. I permit emergency treatment procedures to be carried out by the local emergency medical services (Rescue Squad, EMS) and hospitals, until such time as the parent or guardian can be contacted for consent. I agree that any medical expenses will be billed directly to me or to my insurance company.

Please indicate any allergies (e.g. stings, asthma) or medical conditions requiring medication:

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Participant is responsible for carrying and administering any and all medications for the above condition.

Name and phone of family physician (optional): _________________________________

PROMISE OF RESPECT: I further understand that there is an expectation to respect self, the staff and others at all times. Respect means treating each person encountered in a caring and thoughtful way.

SIGNATURE OF PARENT(S) OR GUARDIAN(S) ___________________________________ DATE:_____________

IF PARTICIPANT IS UNDER THE AGE OF 18

SIGNATURE OF PARTICIPANT: ____ DATE:_____________