

**MEDICAL WAIVER AND EMERGENCY INFORMATION
FOR MINOR PARTICIPANTS IN AQUARIUM PROGRAMS**

I am the parent or guardian of the minor named below and have the legal capacity and authority to act on his or her behalf. I sign this form and the accompanying Agreement to Waive and Release All Claims in consideration for permission by the Monterey Bay Aquarium for the minor to participate in the program named below. In doing so, I agree that all of the terms of the Agreement shall apply to any claims relating to the participation of the minor in the program. This includes (but is not limited to) my agreements to waive and release all claims and to indemnify and hold the Monterey Bay Aquarium Foundation and its representatives harmless against any claims.

I understand that Aquarium will take reasonable precautions to prevent accidents, administer simple first aid for all minor injuries, and call parents and/or a doctor whenever necessary. I am aware that there are risks to participation in the program, and I voluntarily consent to the participation of the minor in the program.

I confirm that the minor is in good health. I hereby give my consent to representatives of the Aquarium to provide all emergency medical or dental care prescribed by a duly licensed health care provider. I understand that care may be given under whatever conditions are necessary to preserve the well being, limb or life of the minor.

Name of Minor: _____ Age: _____

Doctor's Name and Telephone Number: _____ (____) _____

If any of the following conditions apply to the participating child, participation in the program may not be advised without further evaluation. Please circle any or all that apply.

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| 1) Currently have a cold or congestion | 8) Diabetes | |
| 2) Recent or current ear infection | 9) Recently had an operation or illness. | 14) Recurrent back problems back or spinal injuries/surgery. |
| 3) Nervous system disorder | 10) Currently taking medications that carry a warning about any impairment of physical or mental abilities | 15) Under the care of a physician or have chronic illness. |
| 4) A history of respiratory disease | 11) History of seizures, dizziness, or fainting | 16) Allergic Reactions |
| 5) Behavioral health, mental or psychological disorders | 12) History of sinus problems | 17) Current asthma, emphysema, tuberculosis |
| 6) History of heart conditions | 13) Currently prescribed an inhaler (prescribed inhalers MUST be brought to the program) | 18) Other (please note below) |
| 7) Re-current ear problems, ear tubes, ear disease or surgery. | | 19) None of these apply |

Explanation of any circled condition(s):

I understand that past and present medical conditions may contradict participation in this activity as well as elevate the risk of injuries, including but not limited to, pressure related injuries affecting the lungs, sinuses and ears, drowning, panic and other serious injury or death.

Emergency contact (name and telephone number):

Name Telephone

Onsite Legal Guardian or Authorized Representative:

Name: _____ Cell: (____) _____
Parent, Legal Guardian or Authorized Representative

Signature: _____ Date: _____
Parent, Legal Guardian or Authorized Representative