BRAZOS VALLEY MUSEUM of Natural History

# NATURE CAMP LIABILITY WAIVER

Camper Name: _____ Camper Age: _____

Date of Camp: _____

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## 1. Emergency Contact PLEASE PRINT NEATLY

Name_____

Phone _____ Relationship to Camper_____

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## 2. Medical Insurance Information

This camper is covered by family medical/hospital insurance. YES_____ NO_____

Insurance Company_____

Policy Number_____

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## 3. Immunization and Allergy History

Date of Last Tetanus shot_____

List Drug Allergies_____

List Food Allergies_____

Other Medical Problems or restrictions_____

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Please provide in the space below any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. (*Attach additional information if needed)*

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## 4. Camp Pick-Up

If someone else will be picking up your child from camp, attach a note or designate their name and information below.

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## Parent/Guardian Authorization for Health Care:

I, we, the parent/parents/legal guardians of the above camper, for and in consideration of my child's participation in a public program under the supervision of the BRAZOS VALLEY MUSEUM OF NATURAL HISTORY, hereby agree and promise not to hold the BRAZOS VALLEY MUSEUM OF NATURAL HISTORY, nor its employees and others who are assisting, responsible for any loss, damages or personal injuries that our child may receive as a result of such participation. This waiver of liability expressly includes any activity related to or occurring during any Brazos Valley Museum Camp session and responsibility for any loss, damages, or personal injuries that you may receive therefore.

I understand that there are some risks inherent in the activities that are included in the class, but willingly assume these risks in order to participate. I also agree to instruct my child to follow all instructions and procedures in order to maintain a maximum level of safety. I give my permission for any emergency medical care or treatment by a physician, surgeon, hospital, or medical care facility that may be required.

Signature of Parent/Guardian_____

Date_____