



# Personal Release Minor

For good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, I hereby consent and agree to the following:

I hereby grant to Nevada Blind Children's Foundation (NBCF), and others working for NBCF or on its behalf, and each of its respective licensees, successors and assigns (each a "Releasee"), the irrevocable, royalty-free, perpetual, unlimited right and permission to use, distribute, publish, exhibit, digitize, broadcast, display, modify, create derivative works of, reproduce or otherwise exploit my name, picture, likeness and voice (including any video footage of the same) (collectively, "Media"), or to refrain from so doing, anywhere in the world, by any persons or entities deemed appropriate by NBCF, for any purpose (except defamatory) including, without limitation, any use for educational, advertising, non-commercial or commercial purposes in any manner or media whatsoever (whether known or hereafter devised) including, without limitation, on the internet, in print campaigns, in-store and via television. I agree that I have no interest or ownership in any of the Media.

I shall have no right of approval, no claim to compensation and no claim (including, without limitation, claims based upon invasion of privacy, defamation or right of publicity) arising out of any use, alteration, blurring, illusionary effect or use in any composite form of my name, picture, likeness and voice. I agree that nothing in this Release will create any obligation on NBCF to make any use of the Media or the rights granted in this Release. I hereby release and hold harmless Releasees from any claim for injury, compensation or negligence resulting or arising from any activities authorized by this Release and any use of the Media by NBCF.

NAME OF PARTICIPANT (please print) \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

Release for Minors (those under the age of eighteen): I, the undersigned, being a parent or guardian of the minor, hereby consent to the foregoing conditions and warrant that I have the authority to give such consent. DATE \_\_\_\_\_

NAME OF PARENT/LEGAL GUARDIAN (print) \_\_\_\_\_

**SIGNATURE OF PARENT/LEGAL GUARDIAN** \_\_\_\_\_

PARENT/LEGAL GUARDIAN EMAIL \_\_\_\_\_



# Authorization To Release Form

This document identifies people who are authorized to pick-up and/or be contacted regarding the below-named child. Persons listed on this form are understood to be contacts for Nevada Blind Children's Foundation (NBCF) to use while your child is in the care of NBCF, and able to be contacted to pick-up the child as needed (due to illness, behavior, or at the end of the session). The person dropping off/picking up the child must sign them in and out. A NBCF staff member must witness the signature. Only authorized adults listed on this sheet may pick up children from NBCF. Photo identification may be required at pick up, for your child's safety.

This form is valid for all programs and day camps through the 2019-20 school year. Please notify Nevada Blind Children's Foundation if there are any changes to this form 702.735.6223.

### Childs Information:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

### Child lives with:

Mother  Father  Both: Together  Both: Separately  Other: \_\_\_\_\_

I authorize the following adults to pick-up my child from NBCF as necessary should he/she need to leave NBCF early due to illness, injury, or behavior, and at the end of the session. I have informed them that they are listed here and might be contacted.

Nevada Blind Children's Foundation will only release participants to adults listed here, regardless of their relationship to the child, or being listed on another form. Therefore, please make sure to list all appropriate guardians, parents, relatives, and friends. Please be attentive to when your child's program ends and have an adult, listed here, scheduled to pick him/her up.

### Additional Contacts – If the above are unreachable these will be contacted in case of child illness/behavior

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

My child takes Paratransit. Paratransit ID#: \_\_\_\_\_

The above-listed people have my permission to pick-up my child from Nevada Blind Children's Foundation.

I hereby give permission to Nevada Blind Children's Foundation to arrange/provide any necessary program-related transportation for my child (e.g. specialty day camp day-trip transportation). Parents will be notified in advance of all field trips and may be given the option of drive their child.

Parent or Guardian (Print Name) \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_



# Health and Medical History

Date: \_\_\_\_\_

The information on this form is confidential and helps us provide the best care for your child. Some information (like ethnicity) is requested for funding reporting purposes. You and your child's information will remain confidential at all times, but as a condition of funding, NBCF is required to provide data points such as gender, disability, and ethnicity. We appreciate your help in providing this information. Please notify NBCF staff if there are changes to this form.

Child's name: Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  
Grade: \_\_\_\_\_ VI Teacher: \_\_\_\_\_ School: \_\_\_\_\_

### Contact Information:

Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Email: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Gender:  Male  Female  
Ethnicity:  Asian/Pacific Islander  Black/African American  White/Caucasian  
 Latino/Hispanic  Native American  Multi-ethnic, please specify: \_\_\_\_\_

Child lives with:  Mother  Father  Both: Together  Both: Separately  Other: \_\_\_\_\_  
1<sup>st</sup> Parent's/Guardian's Name: \_\_\_\_\_ Email: \_\_\_\_\_

Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Employer Name & Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

2<sup>nd</sup> Parent's/Guardian's Name: \_\_\_\_\_ Email: \_\_\_\_\_  
Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Employer Name & Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### Additional Contacts – If the above are unreachable these will be contacted in case of child illness/behavior

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### Allergies (Medication, food, animals, other)

### Reaction and management of reaction

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

### Medical Treatment while at NBCF:

The following over-the-counter medications are used at NBCF under the recommendation of NBCF's overseeing physician and nurse. Feel free to cross out any products that you do not want your child to have.

I give permission for the following medications to be administered for common ailments:

|         |          |             |                 |                        |
|---------|----------|-------------|-----------------|------------------------|
| Tums    | Lip Balm | Cough Drops | Bee sting swabs | Benadryl, 25mg & cream |
| Tylenol | Advil    | Sunscreen   | Aloe Vera gel   | Antibiotic cream       |

Pediatrician: \_\_\_\_\_ Phone: \_\_\_\_\_

Ophthalmologist: \_\_\_\_\_ Phone: \_\_\_\_\_

Therapist: \_\_\_\_\_ Phone: \_\_\_\_\_

Other Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_



Health History
Vision Impairment

Diagnosis: \_\_\_\_\_

- Low Vision (20/60 – 20/200) Legally Blind (20/200 or worse with best correction in best eye) Blind (light only)

If low vision or legally blind; acuity with best correction Near \_\_\_\_\_ Far \_\_\_\_\_

Reading Medium: Non Reader Large Print Braille Audio

Mobility: No Devices Cane Modified Cane/Walker Non Mobile

Additional Information

Diet: Regular Feeding Tube other (please explain) \_\_\_\_\_

Lavatory: No assistance required Some assistance required Requires diaper with full assistance

No Additional disabilities and on grade/age level No additional disabilities and NOT on grade level

Additional disabilities (please explain): \_\_\_\_\_

- One-to-one adult assistance required Some assistance required No assistance required

Please note: NBCF does not allow peanuts and/or peanut based products for snacks and meals. NBCF does provide programs with animal interactions. Please make sure your responses are thorough and detailed.

Please provide additional information about the participant, include general behavior; physical, emotional, or mental health; activities child should be exempt from for medical reasons; and dietary or other restrictions.

Immunizations – give month/year of the last immunization/booster or attach a copy of the official record:

Tetanus Measles/Mumps/Rubella Hepatitis A Meningitis
Chicken Pox Diphtheria/Pertussis (DtaP/DT) Hepatitis B Other/Specify:

Insurance Information – Is the participant covered by family medical/hospital insurance? Yes No

Carrier/Plan Name: \_\_\_\_\_ Group#: \_\_\_\_\_

Carrier Address: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to Participant: \_\_\_\_\_

Insurance ID Number: \_\_\_\_\_

Social Security # \_\_\_\_\_

Authorization to Provide Necessary Treatment or Emergency Care

I hereby give permission to medical personnel selected by the NBCF Executive Director to order x-rays, routine tests, or other treatment; to release any records necessary for insurance purposes; to release a diagnosis and prescription to NBCF staff; and to provide or arrange any necessary related transportation for my child. If I cannot be contacted, I hereby give permission to the physician selected by NBCF to secure and administer treatment, including hospitalization. This completed form may be photocopied for programs outside of NBCF's center. Both sides of this form are correct and complete as far as I know, and the person herein described has permission to engage in all NBCF activities except as noted on this form.

Parent/Guardian's Signature \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_



# Participation/Restriction Form

During NBCF's Summer Day Camp your child will be participating in the following activities:

- ✓ **Sports and Recreation** games such as scooter games, bowling, tag games etc. These games will include running, jumping, skipping and throwing
- ✓ **STEM- Science Technology, Engineering and Math** activities will include the science of bubbles and engineering a robot
- ✓ **Arts & Crafts** include painting, coloring, gluing and potting plants
- ✓ **Challenge Station** games include relays, sports and scavenger hunts
- ✓ **Group Play** – programming will include high energy activity such as ship to shore, red light green light, tag as well as low key programs such as coloring, kinetic sand and tactile games.
- ✓ **Inside/outside** – the majority of our programs will take place inside our facility. While outdoors we will do our best to be in the shade as much as possible and water is always available for the campers.
- ✓ **Field Trips** will include being outdoors in a park setting, active play games including beep baseball and interacting with animals

If you do not wish to have you child participate in any of the above activities or your child has limitations that the staff need to know about please indicate below

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I \_\_\_\_\_ give my child \_\_\_\_\_  
*parent/guardian print name* *child's name*

permission to participate in the activities provided by Nevada Blind Children's Day Camp program during Spring Break Camp. I have listed any limitations or exclusions that are necessary for my child while participating in Nevada Blind Children's Day Camp. I will inform camp staff if limitations or exclusions change over the course of the camp.

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date