



“Inspiring a Passion for Learning”

ADULT CHAPERONE RELEASE

Print Name (first/last) Mr Mrs Ms (circle one) _____

Staff member of participating school? Yes No

Participating School Name _____

I recognize that I am agreeing to 1) accept general liability for my participation in this program aboard *S/V Carlyn* and 2) hold harmless Salish Sea Expeditions and Four Winds, Inc. (owner of the vessel), their officers, directors, employees and volunteers from all claims, liability or lawsuits arising from my behavior or disregard of regulations while participating on a Salish Sea Expedition. I give my permission to use photographs of myself/my child in publications and websites that feature Salish Sea Expeditions, unless specifically agreed upon otherwise with an employee or representative of Salish Sea Expeditions.

I certify that I am aware of the inherent dangers of sailing and water-related activities and hereby assume such risks. I also accept liability for my motor vehicle transportation by Salish Sea Expeditions.

Date: _____ Signature: _____

Home Phone: (____) _____ Work Phone: (____) _____

Cell phone: (____) _____ Preferred Phone: H W C

Mailing address: _____

City: _____ State: _____

Zip: _____

Email: _____

Print Clearly

Name of chaperone:

Name of school:

MEDICAL & EMERGENCY CONTACT INFORMATION (confidential)

Please complete the checklist below. For all "yes" answers, please elaborate in the space below or on a separate piece of paper.

	<u>Yes</u>	<u>No</u>
Does you currently have (or have a history of) any of the following:		
asthma or any other respiratory problems?		
diabetes?		
allergic reactions to anything (e.g. food, medicines, bites or stings)?		
epilepsy, fainting or dizziness, or seizures?		
cardiac conditions (e.g. heart murmurs, irregular heartbeat)?		
dietary restrictions (e.g. allergies, vegetarian, lactose intolerant)?		
eating disorders (e.g. anorexia, bulimia)?		
pregnancy?		
neck/back/shoulder/knee/ankle/wrist/hand/arm problems?		
any other medical conditions that we should be aware of?		

If you answered "yes" to any of the above, please elaborate here with reactions to allergies and medications.
Be as specific as possible as we may need to provide this information to medical personnel in an emergency. If you will be taking medications during the program (prescribed or over the counter), please specify what and how often.

Medical Condition	Name of Medication	Dosage

Allergic Reaction Symptoms: (Be as specific as possible) _____

If you have any fear of the water, please indicate here: _____

In the event of an accident or emergency, you will be transported to a medical facility. In the event that we are unable to communicate with you, do you give medical personnel permission to begin treatment? _____

Your doctor: _____ Telephone#: _____

Insurance Carrier: _____ Policy #: _____

Please provide an additional emergency contact:

Name (Print) _____

Relation _____ Telephone _____