



# WAYCROSS COMMUNITY MEDIA

2086 Waycross Road  
Forest Park, OH 45240-2717  
(513) 825-2429 www.waycross.org

## Parental Consent & Liability Agreement

I hereby warrant that I am parent or guardian of:

\_\_\_\_\_ ( name )

- I give my permission for my (son/daughter/ward) to attend training workshops and participate in video production activities offered free of charge by the Community Programming Board of Forest Park, Greenhills, and Springfield Township (CPB).
- I extend my permission for my (son/daughter/ward) to utilize the Waycross facilities owned by the CPB to produce programming for cable access television presentation.
- I understand that if my son/daughter appears in Waycross programming, this appearance may be used for cablecast, webcast (internet), promotions, commercials, "best of" retrospectives, and entry into service or industry awards competitions. I acknowledge that you are acting in reliance on this release in connection with the production and use of this appearance.
- I agree to accept legal and financial responsibility for damages and/or losses caused by my (son/daughter/ward) or by his/her negligence using said equipment. I agree to pay for all costs of repair or replacement of damaged and/or lost equipment, at the equipment owner's discretion.
- I hereby agree Waycross Community Media, it's staff, volunteers and producers; trustees of the Community Programming Board, it's member organizations, and the owners of the facilities utilized by Waycross for productions, shall not be held liable for any injury or loss which my (son/daughter/ward) may sustain while participating in any activity sponsored by the foregoing organizations. I am aware that there may be a risk involved in participating in Waycross activities, and certify that my (son/daughter/ward) is physically capable of participating in any of the sponsored programs. I further agree to hold harmless from any claim, whatsoever, Waycross Community Media, the Community Programming Board, it's member organizations and the owners of the facilities utilized.

\_\_\_\_\_  
Parent/Guardian signature

\_\_\_\_\_  
Parent/Guardian printed name

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
Daytime Phone

\_\_\_\_\_  
Evening Phone



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## Emergency Medical Authorization

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for minors who become ill or injured while under Waycross authority when parents or guardians cannot be reached.

### Minor's Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_

### Residential Parent or Guardian:

Mother: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_  
Father: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_  
Other Name(s): \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

### Name of Relative or Childcare Provider:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_

-- PART I OR PART II MUST BE COMPLETED --

### PART I - To Grant Consent

I hereby give consent for the following medical providers and local hospital to be called:

Providers and local hospital to be called:

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_  
Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_  
Medical Specialist: \_\_\_\_\_ Phone: \_\_\_\_\_  
Local Hospital: \_\_\_\_\_ ER Phone: \_\_\_\_\_

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Facts concerning the minor's medical history including allergies, medication being taken and any physical impairments to which a physician should be alerted:

\_\_\_\_\_

Parent/guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

### PART II - Refusal to Consent

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the Waycross authorities to take the following actions:

\_\_\_\_\_

Parent/guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_