CITY OF SUNRISE

FIRE-RESCUE DEPARTMENT

10440 W. OAKLAND PARK BLVD., SUNRISE, FLORIDA 33351

EXPLORER'S PERMISSION AND RELEASE FORM

I. NAME OF EXPLORER

__________________________________,(name) Explorer Scout, who is ______ years of age, wishes to participate in the activities of post #310, sponsored by the City of Sunrise Fire-Rescue Department.

II. NOTICE OF ACTIVITIES AND EXPOSURE TO RISK

Activities of the Post may include;

1. Receiving instruction on the use of fire equipment, including live hose streams, ladder climbs, generators, power tools, and breathing apparatus
2. Extinguishing controlled training fires as a member of a team
3. Riding in an emergency vehicle, such as a fire truck or rescue truck, during response to an actual emergency call
4. Gathering information, carrying messages, and dispensing food and drink to firefighters at the periphery of an emergency scene, during a prolonged emergency
5. Instruction in, and provision of, basic medical care and first-aid

III. EXPLORER'S PHYSICAL LIMITATIONS

The Explorer is subject to the following disabilities: (please list below)

____

____

The disabilities limit or prevent the Explorer from participating in the following activities: (please list below)

____

____

IV. RELEASE FROM LIABILITY

1. I am the parent or legal guardian of the Explorer Scout; or I am over the age of 18 years.
2. I have read Section II above, notifying me of the activities an Explorer is likely to take part in as a member of the Sunrise Fire-Rescue Explorer Post # 310
3. I agree that the Explorer will observe the physical limitations I have listed above
4. I understand that an Explorer could be accidentally injured or harmed while taking part in Explorer activities
5. In consideration for allowing the individual named in Section I above to participate in the named activities, I agree to release the City of Sunrise, its officers, employees and agents (hereinafter referred to as the "City") from liability as follows:

   A. **ACTS COVERED BY RELEASE:**
      1. I release the "City" from liability for acts or omissions that are partially the negligence of the "City"
      2. I release the "City" from liability for acts or omissions that are the negligence of persons other than the "City"
      3. I release the "City" from liability for acts or omissions of the City's officers, agents or employees, if they are not acting officially on the behalf of the "City" while committing the act or omission by which an Explorer is harmed.

   B. **DAMAGES COVERED BY RELEASE**
      1. I release the "City" from liability for all claims, damages, costs, attorney's fees or expenses arising out of harm to the Explorer, unless the Explorer is harmed solely by its negligence.

   C. **TIME COVERED BY RELEASE**
      1. I release the "City" from liability for harm to the Explorer whether the harm is evident immediately or is discovered only on some later date; except I do not release them from liability for their sole negligence.

   D. **PERSONS BOUND BY THIS RELEASE**
      1. I make this release on the behalf of the Explorer, myself, and all other members of the Explorer's family

2. By signing below, I permit the Explorer Scout to participate in activities of the Explorer Post # 310 and I agree to the terms of the release set forth in this form.

____
SIGNATURE

____
RELATIONSHIP TO EXPLORER

____
DATE

____
NOTARY SEAL

CITY OF SUNRISE

FIRE-RESCUE DEPARTMENT

10440 W. OAKLAND PARK BLVD., SUNRISE, FLORIDA 33351

RELEASE AND HOLD HARMLESS

The undersigned being the age of fourteen (14) or older, does hereby request the City of Sunrise of Broward County, Florida for permission to ride as an observer only in an authorized City of Sunrise motor vehicle unit.

If permission is granted, I hereby agree to obey, at all times, all instructions, orders and commands given to me by unit members in command of any vehicle in which I may be riding. I fully realize and appreciate the basic nature of Emergency Medical work and the possibility that situations will arise which might result in my being exposed to the danger of physical harm or injury, including but not limited to motor vehicle accidents. I, nevertheless, freely accept these risks.

WHEREFORE, in consideration of the educational benefits to be received and the granting of the above request, I hereby agree to hold the City of Sunrise, it's councilmen, it's employees, and its agents harmless from all liability to me for personal injury or property damage sustained during the period of time I may be in the capacity of an observer or passenger, as aforesaid.

Name: ____

Age: ____________ Phone: ______________________

Address: _____________________________________

____

Signature: __________________________________

STATE OF FLORIDA

County of ______________________

I, an officer authorized to take acknowledgements, hereby certify that this ______ day of ________________, 20___ personally appeared before me ____________________________, to me well known to be the person described in the foregoing release, and acknowledged to me that he/she executed the same freely and voluntarily for the uses and purposes therein expressed.

____

Notary Public

CITY OF SUNRISE
Fire-Rescue Explorers

APPLICATION

All applications must be filled out with either a blue or black pen. Please fill out the application truthfully and thoroughly, or it will not be processed.

NAME: ______________________________ DATE OF BIRTH: __________

ADDRESS: ________________________ CITY: ___________ ZIP: ______

HOME PHONE: _____-_____-_____ CELL PHONE: _____-_____-_____

LEGAL GUARDIAN: ____

EMERGENCY CONTACT NUMBERS: _________________________________

SCHOOL YOU ATTEND: _________________________ GRADE: __________

LIST CLASSES AND GRADES: ___________________________________

____

____

DO YOU DRIVE? ______ IF SO, LICENSE NUMBER: ____________________

TRAFFIC VIOLATIONS: ____

HAVE YOU EVER BEEN ARRESTED? ______ IF YES, EXPLAIN: ____________

____

CHECK ALL THAT APPLY:

☐ - FIRST AID ☐ - EMT ☐ - PREVIOUS EXPLORER EXPERIENCE

☐ - CPR ☐ - FIRE

DO YOU BELONG TO ANY ORGANIZATIONS? ______ IF SO, LIST: ____________

____

____

ARE YOU EMPLOYED? ______ IF SO, LIST: _____________________________

____

APPLICATION
CON'T

WRITE IN YOUR OWN WORDS, WHY YOU WANT TO BE A PART OF THE CITY OF SUNRISE FIRE-RESCUE EXPLORER PROGRAM, AND WHAT YOUR EXPECTATIONS ARE WITH THIS POST IF YOU WERE ACCEPTED. **(MIN. 100 WORDS)**

APPLICATION
CON'T

I HEREBY CERTIFY THAT I HAVE ANSWERED ALL OF THE ABOVE QUESTIONS TRUTHFULLY AND ACCURATELY. I AUTHORIZE THE CITY OF SUNRISE FIRE-RESCUE TO MAKE INQUIRIES INTO MY SCHOOL, POLICE DEPARTMENT AND EMPLOYER, CONCERNING MY FITNESS AND MORAL CHARACTER

SIGNATURE OF APPLICANT____DATE: _____________

I HEREBY ACKNOWLEDGE AND UNDERSTAND ALL OF THE ABOVE AND HAVE NO OBJECTIONS TO MY SON OR DAUGHTER JOINING THE CITY OF SUNRISE FIRE-RESCUE EXPLORER PROGRAM.

SIGNATURE OF GUARDIAN ____DATE: _____________

TURN IN COMPLETED APPLICATION TO
ATTN: LIEUTENANT TIM EWING
SUNRISE FIRE RESCUE DEPARTMENT
10440 W. OAKLAND PARK BLVD
SUNRISE, FL. 33351
- OR -
EMAIL TEWING@SUNRISEFL.GOV

MEETINGS ARE HELD EVERY MONDAY 6:30 PM - 9:30 PM, AT SUNRISE FIRE STATION #92, LOCATED AT 13721 NW 21 ST.

DEPARTMENT USE ONLY – DO NOT WRITE BELOW

REVIEWED BY: _________ DATE: ______________

☐ - ACCEPTED

☐ - DENIED
EXPLAIN____

☐ - POSTPONED
EXPLAIN____

YOUTH PARTICIPANT

○ Exploring Post ○ Explorer Club Number:

If applicant has an unexpired participant certificate, participation may be accomplished at no charge by transferring the registration. Mark and attach a copy of the certificate.

○ Transfer application Transfer from council no.: ○ Exploring Post ○ Explorer Club Number:

Name and address information **(Please print one letter in each space—press hard, you are making a copy.)**

First name **(No initials or nicknames)** Middle name Last name Suffix

Country Mailing address City State Zip code

U S

Phone - - Date of birth (mm/dd/yyyy) / / Grade

Ethnic background:
○ Black/African American ○ Native American ○ Alaska Native ○ Asian
○ Caucasian/White ○ Hispanic/Latino ○ Pacific Islander ○ Other

School

Gender: ○ Male ○ Female

Email address (Post youth participant only) @

Parent/guardian information

Select relationship: ○ Parent ○ Guardian ○ Grandparent ○ Other (specify)

First name **(No initials or nicknames)** Middle name Last name Suffix

Country Mailing address City State Zip code

U S

Home phone - - Date of birth (mm/dd/yyyy) / / Occupation Employer Gender: ○ M ○ F

Business phone - - X Ext. Previous Exploring experience Cell phone - -

Parent/guardian email address @

I have read the attached information sheet and approve the application (signature of parent/guardian required if applicant is under 18 years of age).

Signature of post or club leader

Date / /

Signature of parent/guardian

Participation fee $. Paid: Cash Check No. ________ Credit card

Signature of Explorer

LOCAL OFFICE COPY

Retain on file for three years. 524-009

YOUTH PARTICIPANT

◯ Exploring Post ◯ Explorer Club Number:

If applicant has an unexpired participant certificate, participation may be accomplished at no charge by transferring the registration. Mark and attach a copy of the certificate.

◯ Transfer application Transfer from council no.:

◯ Exploring Post ◯ Explorer Club Number:

Name and address information **(Please print one letter in each space—press hard, you are making a copy.)**

First name **(No initials or nicknames)** Middle name Last name Suffix

Country U S Mailing address City State Zip code

Phone - - Date of birth (mm/dd/yyyy) / / Grade

Ethnic background:
◯ Black/African American ◯ Native American ◯ Alaska Native ◯ Asian
◯ Caucasian/White ◯ Hispanic/Latino ◯ Pacific Islander ◯ Other

School

Gender: ◯ Male ◯ Female

Email address (Post youth participant only) @

Parent/guardian information

Select relationship: ◯ Parent ◯ Guardian ◯ Grandparent ◯ Other (specify)

First name **(No initials or nicknames)** Middle name Last name Suffix

Country U S Mailing address City State Zip code

Home phone - - Date of birth (mm/dd/yyyy) / / Occupation Employer Gender: ◯ M ◯ F

Business phone - - Ext. X Previous Exploring experience Cell phone - -

Parent/guardian email address @

I have read the attached information sheet and approve the application (signature of parent/guardian required if applicant is under 18 years of age).

Signature of post or club leader Date / /

Signature of parent/guardian

Participation fee $. Paid: ☐ Cash ☐ Check No. ________ ☐ Credit card

Signature of Explorer

POST OR CLUB COPY

Retain on file for three years. 524-009

YOUTH PARTICIPANT

○ Exploring Post ○ Explorer Club Number: [ ][ ][ ][ ]

If applicant has an unexpired participant certificate, participation may be accomplished at no charge by transferring the registration. Mark and attach a copy of the certificate.

○ Transfer application Transfer from council no.: [ ][ ][ ] ○ Exploring Post ○ Explorer Club Number: [ ][ ][ ][ ]

Name and address information **(Please print one letter in each space—press hard, you are making a copy.)**

First name **(No initials or nicknames)** Middle name Last name Suffix

Country: U S Mailing address City State Zip code

Phone ___ - ___ - ____ Date of birth (mm/dd/yyyy) __ / __ / ____ Grade

Ethnic background:
○ Black/African American ○ Native American ○ Alaska Native ○ Asian
○ Caucasian/White ○ Hispanic/Latino ○ Pacific Islander ○ Other

School

Gender: ○ Male ○ Female

Email address (Post youth participant only) @

Parent/guardian information

Select relationship: ○ Parent ○ Guardian ○ Grandparent ○ Other (specify)

First name **(No initials or nicknames)** Middle name Last name Suffix

Country: U S Mailing address City State Zip code

Home phone ___ - ___ - ____ Date of birth (mm/dd/yyyy) __ / __ / ____ Occupation Employer Gender: ○ M ○ F

Business phone ___ - ___ - ____ X Ext. Previous Exploring experience Cell phone ___ - ___ - ____

Parent/guardian email address @

Signature of post or club leader

Date __ / __ / ____

I have read the attached information sheet and approve the application (signature of parent/guardian required if applicant is under 18 years of age).

Signature of parent/guardian

Signature of Explorer

Participation fee $ __ . __ Paid: ☐ Cash ☐ Check No. ________ ☐ Credit card

EXPLORER COPY/RECEIPT

Retain on file for three years.

The City of Sunrise Fire Rescue Explorer Post #310

Rules and Regulations Acknowledgement Form

I, ________________________________, on this ___ day of ________________in the year 20___ have agreed to abide by all rules and regulations as stated in the City of Sunrise Fire-Rescue Explorer Post #310 Rules and Regulations Handbook.

By signing this agreement, you acknowledge that you have read and understood the City of Sunrise Fire-Rescue Explorer Rules and Regulations Handbook, and that you agree to be bound by the terms and conditions as stated within. Failure to follow these Rules and Regulations can lead to suspension and or termination from the Post.

Explorer Signature

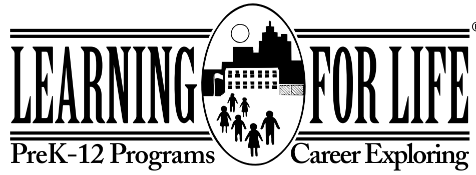
________________________________ Date: ____/_____/_____

Parent Signature

________________________________ Date: ____/_____/_____

Post Advisor Signature

_________________________________ Date: ____/_____/_____



Learning for Life and Exploring Annual Health and Medical Record

(Valid for 12 calendar months)

Policy on Use of the Learning for Life and Exploring Annual Health and Medical Record

In order to provide better care for its members and to assist them in better understanding their own physical capabilities, Learning for Life recommends that everyone who participates in a Learning for Life or Exploring event have an annual medical evaluation by a certified and licensed health-care provider—a physician (MD or DO), nurse practitioner, or physician assistant. Providing your medical information on this form will help ensure you meet the minimum standards for participation in various activities. Note that adult leaders must always protect the privacy of unit participants by protecting their medical information.

Parts A and B are to be completed at least annually by participants in all Learning for Life and Exploring events. This health history, parental/guardian informed consent and hold harmless/release agreement, and talent release statement is to be completed by the participant and parents/guardians.

Part C is the physical exam that is required for participants in any event that exceeds 72 consecutive hours or when the nature of the activity is strenuous and demanding. Service projects or work weekends may fit this description. Part C is to be completed and signed by a certified and licensed heath-care provider—physician (MD or DO), nurse practitioner, or physician assistant. It is important to note that the height/weight limits must be strictly adhered to when the event will take the post/club/group more than 30 minutes away from an emergency vehicle or an accessible roadway, or to remote areas.

Risk Factors

Based on the vast experience of the medical community, Learning for Life has identified that the following risk factors may define your participation in various outdoor activities.

- Excessive body weight
- Heart disease
- Hypertension (high blood pressure)
- Diabetes
- Seizures
- Lack of appropriate immunizations
- Asthma
- Allergies/anaphylaxis
- Muscular/skeletal injuries
- Psychiatric/psychological and emotional difficulties

For more information on medical risk factors, visit the Safety First Guidelines on www.learningforlife.org.

Prescriptions

The taking of prescription medication is the responsibility of the individual taking the medication and/or that individual's parent or guardian. An adult leader, after obtaining all the necessary information, can agree to accept the responsibility of making sure a youth takes the necessary medication at the appropriate time, but Learning for Life does not mandate or necessarily encourage the leader to do so. Also, if state laws are more limiting, they must be followed.

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Part A: Informed Consent, Release Agreement, and Authorization

Full name: ______________________________

DOB: ______________________________

Outing participants:
Post/club/group No.: ______________________________
or staff position: ______________________________

Informed Consent, Release Agreement, and Authorization

I understand that participation in Learning for Life activities involves a certain degree of risk. I have carefully considered the risk involved and have given consent for myself and/or my child to participate in these activities. I understand that participation in these activities is entirely voluntary and requires participants to abide by applicable rules and standards of conduct. I release Learning for Life, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all claims or liability arising out of this participation.

I approve the sharing of the information on this form with Learning for Life volunteers and professionals who need to know of medical situations that might require special consideration for the safe conducting of Learning for Life activities.

In case of an emergency involving me or my child, I understand that every effort will be made to contact the individual listed as the emergency contact person. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose to the adult in charge examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities

☐ Without restrictions

☐ With special considerations or restrictions (list) ______________________________

____

Talent Release Agreement

I hereby assign and grant to Learning for Life the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child by Learning for Life, and I hereby release Learning for Life from any and all liability from such use and publication.

I hereby authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of Learning for Life, and I specifically waive any right to any compensation I may have for any of the foregoing.

☐ Yes ☐ No

ADULTS AUTHORIZED TO TAKE YOUTH TO AND FROM EVENTS

You must designate at least one adult. Please include a telephone number.

1. Name ______________________________ Telephone ______________________________

2. Name ______________________________ Telephone ______________________________

3. Name ______________________________ Telephone ______________________________

Adults NOT authorized to take youth to and from events:

1. Name ______________________________

2. Name ______________________________

3. Name ______________________________

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity.

Participant's name: ______________________________ Date: ______________

Participant's signature: ______________________________ Date: ______________

Parent/guardian signature for youth: ______________________________ Date: ______________

(If participant is under the age of 18)

Second parent/guardian signature for youth: ______________________________ Date: ______________

(If required; for example, CA)

This Annual Health and Medical Record is valid for 12 calendar months.

Part B: General Information/Health History

Full name: ______________________________

DOB: ______________________________

Outing participants:
Post/club/group No.: ______________________
or staff position: ______________________

Age: ____________ Gender: ____________ Height (inches): ____________ Weight (lbs.): ____________

Address: ____

City: ____________________ State: ____________ ZIP code: ________ Telephone: ____________

Post/club/group leader: ______________________________ Mobile phone: ____________________

Council Name/No.: ______________________________ Post/club/group No.: ____________

Health/Accident Insurance Company: ____________________ Policy No.: ____________________

Please attach a photocopy of both sides of the insurance card. If you do not have medical insurance, enter "none" above.

In case of emergency, notify the person below:

Name: ______________________________ Relationship: ____________________

Address: ______________________ Home phone: ____________ Other phone: ____________

Alternate contact name: ______________________________ Alternate's phone: ____________________

Health History

Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Explain
		Diabetes	**Last HbA1c percentage and date**:
		Hypertension (high blood pressure)	
		Adult or congenital heart disease/heart attack/chest pain (angina)/heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
		Family history of heart disease or any sudden heart-related death of a family member before age 50.	
		Stroke/TIA	
		Asthma	**Last attack date**:
		Lung/respiratory disease	
		COPD	
		Ear/eyes/nose/sinus problems	
		Muscular/skeletal condition/muscle or bone issues	
		Head injury/concussion	
		Altitude sickness	
		Psychiatric/psychological or emotional difficulties	
		Behavioral/neurological disorders	
		Blood disorders/sickle cell disease	
		Fainting spells and dizziness	
		Kidney disease	
		Seizures	**Last seizure date**:
		Abdominal/stomach/digestive problems	
		Thyroid disease	
		Excessive fatigue	
		Obstructive sleep apnea/sleep disorders	**CPAP: Yes** ☐ **No** ☐
		List all surgeries and hospitalizations	**Last surgery date**:
		List any other medical conditions not covered above	

Part B: General Information/Health History

Full name: ____

DOB: ____

Outing participants:
Post/club/group No.: ______________________________
or staff position: ______________________________

Allergies/Medications

Are you allergic to or do you have any adverse reaction to any of the following?

Yes	No	Allergies or Reactions	Explain	Yes	No	Allergies or Reactions	Explain
		Medication				Plants	
		Food				Insect bites/stings	

List all medications currently used, including any over-the-counter medications.

☐ **CHECK HERE IF NO MEDICATIONS ARE ROUTINELY TAKEN.**

☐ **IF ADDITIONAL SPACE IS NEEDED, PLEASE INDICATE ON A SEPARATE SHEET AND ATTACH.**

Medication	Dose	Frequency	Reason

☐ **YES** ☐ **NO** **Non-prescription medication administration is authorized with these exceptions:**______________________________

Administration of the above medications is approved for youth by:

______________________________ / ______________________________

Parent/guardian signature **MD/DO, NP, or PA signature (if your state requires signature)**

! **Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication unless instructed to do so by your doctor.** **!**

Immunization

The following immunizations are recommended by Learning for Life. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

Yes	No	Had Disease	Immunization	Date(s)
			Tetanus	
			Pertussis	
			Diphtheria	
			Measles/mumps/rubella	
			Polio	
			Chicken Pox	
			Hepatitis A	
			Hepatitis B	
			Meningitis	
			Influenza	
			Other (i.e., HIB)	
			Exemption to immunizations (**form required**)	

Please list any additional information about your medical history:

____

____

____

____

DO NOT WRITE IN THIS BOX
Review for program or special activity.

Reviewed by:______________________________

Date: ______________________________

Further approval required: ☐ Yes ☐ No

Reason: ______________________________

Approved by:______________________________

Date: ______________________________

Part C: Pre-Participation Physical

This part must be completed by certified and licensed physicians (MD, DO), nurse practitioners, or physician assistants.

Full name: ______________________________

DOB: ______________________________

Outing participants:
Post/club/group No.: ______________________
or staff position: ______________________

You are being asked to certify that this individual has no contraindication for participation in a Learning for Life or Exploring experience.

Examiner: Please fill in the following information:

	Yes	No	Explain
Medical restrictions to participate			

Yes	No	Allergies or Reactions	Explain	Yes	No	Allergies or Reactions	Explain
		Medication				Plants	
		Food				Insect bites/stings	

Height (inches):__________ **Weight (lbs.):**__________ **BMI:**__________ **Blood Pressure:**__________/__________ **Pulse:**__________

	Normal	Abnormal	Explain Abnormalities
Eyes			
Ears/nose/ throat			
Lungs			
Heart			
Abdomen			
Genitalia/hernia			
Musculoskeletal			
Neurological			
Other			

Examiner's Certification

I certify that I have reviewed the health history and examined this person and find no contraindications for participation in a Learning for Life and/or Exploring experience. This participant (with noted restrictions):

True	False	Explain
		Meets height/weight requirements.
		Does not have uncontrolled heart disease, asthma, or hypertension.
		Has not had an orthopedic injury, musculoskeletal problems, or orthopedic surgery in the last six months or possesses a letter of clearance from his or her orthopedic surgeon or treating physician.
		Has no uncontrolled psychiatric disorders.
		Has had no seizures in the last year.
		Does not have poorly controlled diabetes.
		If less than 18 years of age and planning to scuba dive, does not have diabetes, asthma, or seizures.

Examiner's Signature: ______________________ **Date:** __________

Provider printed name: ______________________

Address: ______________________

City: ______________________ State: __________ ZIP code: __________

Office phone: ______________________

Height/Weight Restrictions

If you exceed the maximum weight for height as explained in the following chart and your planned program or special activity will take you more than 30 minutes away from an emergency vehicle/accessible roadway, you may not be allowed to participate.

Maximum weight for height:

Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight
60	166	65	195	70	226	75	260
61	172	66	201	71	233	76	267
62	178	67	207	72	239	77	274
63	183	68	214	73	246	78	281
64	189	69	220	74	252	79 and over	295

LEARNING FOR LIFE® PreK-12 Programs Career Exploring

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The City of Sunrise Fire Rescue Explorer Post #310

PHOTOGRAPHY CONSENT FORM / RELEASE FOR MINOR CHILDREN (Under 18)

I, (Name-Print)____, parent or official guardian of (Explorer's Name-Print)_________________________________hereby grant permission to the City of Sunrise Fire Rescue Department, to take and use: photographs and/or digital images of **my child** for use in news releases, promotional materials, and/or educational materials as follows: printed publications or materials, electronic publications, websites, or social media platforms. I authorize the use of these images without compensation to me. All negatives, prints, digital reproductions and shall be the property of the City Of Sunrise Fire Recue Department.

____
(Signature of Parent or Guardian)

____
(Date)

____
(Signature of Explorer, if over the Age of 18)

ACTIVITY CONSENT FORM AND APPROVAL BY PARENTS OR LEGAL GUARDIAN

FORMULARIO DE CONSENTIMIENTO Y APROBACIÓN DE ACTIVIDAD POR PARTE DE LOS PADRES DE FAMILIA O TUTORES

The recommended use of this form is for the consent and approval for Explorers and guests to participate in a trip, expedition, or activity. It is required for use with flying plans.

El uso recomendado de este formulario es para obtener el consentimiento y aprobación para Explorers e invitados para participar en un viaje, expedición o actividad. Es obligatorio para su oso planes de vuelo.

First name of participant / Nombre del participante: ______________________
Middle initial / Inicial del segundo nombre: ______
Last name / Apellido: ______________________

Birth date (month/day/year) / Fecha de nacimiento (mes/día/año): ______ / ______ / ______
Age during activity / Edad al momento de realizar la actividad: ______

Address / Domicilio: ____

City / Ciudad: ______________________
State / Estado: ______________________
Zip / Código postal: __________

Has approval to participate in (name of activity, orientation flight, outing trip, etc.) / Tiene la aprobación para participar en (nombre de la actividad, vuelo de orientación, excursión, etc.): ______________________
From / De ______ (Date) (fecha) to / a ______ (Date) (fecha)

INFORMED CONSENT, RELEASE AGREEMENT, AND AUTHORIZATION

I understand that participation in Exploring activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the venue, activity coordinators, or local council. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

In case of an emergency involving my child, I understand that efforts will be made to contact me. In the event I cannot be reached, permission is hereby given to the medical provider to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child. Medical providers are authorized to disclose protected health information to the adult in charge and/or any physician or health care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

With appreciation of the dangers and risks associated with programs and activities including preparations for and transportation to and from the activity, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Boy Scouts of America, Learning for Life, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

NOTE: The Boy Scouts of America, Learning for Life and local councils cannot continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. List any restrictions imposed on a child participant in connection with programs or activities below and counsel your child to comply with those restrictions.

List participant restrictions, if any: ______________________

☐ None

CONSENTIMIENTO INFORMADO, CONVENIO DE EXONERACIÓN Y AUTORIZACIÓN

Entiendo que la participación en actividades Exploring implica el riesgo de lesiones personales, incluyendo la muerte, debido a los retos físicos, mentales y emocionales en las actividades que se ofrecen. Se puede obtener información sobre dichas actividades en la sede, con los coordinadores de la actividad o el concilio local. También entiendo que la participación en estas actividades es totalmente voluntaria y requiere que los participantes sigan instrucciones y acaten todas las reglas y normas de conducta pertinentes.

En caso de que mi hijo se vea involucrado en una emergencia, entiendo que se realizarán esfuerzos para contactarme. En caso de que yo no pueda ser localizado, por este medio otorgo permiso al proveedor de servicios médicos para garantizar el tratamiento adecuado, incluyendo hospitalización, anestesia, cirugía o inyecciones de medicamentos para mi hijo. Los proveedores de servicios médicos están autorizados a revelar información médica protegida al adulto a cargo, médico o proveedor de servicios médicos involucrado en la prestación de atención médica para el participante. La Información de salud protegida/Información médica confidencial (PHI/CHI, por sus siglas en inglés) bajo los Estándares de privacidad de información médica individualmente identificable, 45 C.F.R. §§ 160.103, 164.501, etc., y siguientes, como se enmiendan de vez en cuando, incluyen resultados de reconocimientos médicos, resultados de pruebas y el tratamiento proporcionado para fines de evaluación médica del participante, seguimiento y comunicación con los padres o tutor legal del participante, o determinación de la capacidad del participante para continuar en las actividades del programa.

Con reconocimiento de los peligros y riesgos asociados con los programas y actividades incluyendo preparativos y transportación hacia y desde la actividad, en mi propio nombre o en nombre de mi hijo, por este conducto eximo total y completamente, y renuncio a cualquiera y toda reclamación por lesiones personales, muerte o pérdidas que puedan surgir, a la organización Boy Scouts of America, Learning for Life, el concilio local, los coordinadores de la actividad y todos los empleados, voluntarios, grupos involucrados, u otras organizaciones asociadas con cualquier programa o actividad.

NOTA: La organización Boy Scouts of America, Learning for Life y los concilios locales no pueden vigilar continuamente el cumplimiento de los participantes del programa o cualquier limitación impuesta sobre ellos por los padres o proveedores de servicios médicos. Enumerar más abajo las restricciones impuestas a un niño participante en relación con los programas o actividades.

Restricciones del participante, si existen: ______________________

☐ Ninguna

______________________ Participant's signature / Firma del participante
__________ Date / Fecha

______________________ Parent/guardian printed name / Nombre con letra de molde del padre de familia/tutor
______________________ Parent/guardian signature / Firma del padre de familia/tutor
__________ Date / Fecha

______________________ Area code and telephone number (best contact and emergency contact) / Código de área y número telefónico (primer contacto y contacto de emergencia)
______________________ Email (for use in sharing more details about the trip or activity) / Correo electrónico (para informar más detalles sobre el viaje o actividad)

Contact the adult leader with any questions:
Póngase en contacto con el líder adulto si es que tiene preguntas:

Name / Nombre: ______________________
Phone / Teléfono: ______________________
Email / Correo electrónico: ______________________

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