

<u>He'eia Elementary</u> School/Organization	_____ Field Trip Date(s)	_____ Teacher Name & Grade (if applicable)
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**Please print the following information:**

Participant's first, middle, last name	Date of birth (mm/dd/yy)	M F	Zip code
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**Identify participant's ethnicity (check all that apply):**

<input type="checkbox"/> Asian	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Latino	<input type="checkbox"/> Pacific Islander
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian	<input type="checkbox"/> Native American	<input type="checkbox"/> Other _____

**Age category (check all that apply):**

<input type="checkbox"/> Newborn - 2 years old	<input type="checkbox"/> Grades 4 - 5	<input type="checkbox"/> Enrolled in College/University
<input type="checkbox"/> 3 - 4 years old	<input type="checkbox"/> Grades 6 - 8	<input type="checkbox"/> Adult/Parent
<input type="checkbox"/> Kindergarten - Grade 3	<input type="checkbox"/> Grades 9 - 12	<input type="checkbox"/> Educator

**EMERGENCY CONTACT**

Name of primary emergency contact	Relationship to participant	Cell/Preferred phone
Name of secondary emergency contact	Relationship to participant	Cell/Preferred phone

**MEDICAL INFORMATION**

Hospital/Clinic preference	
Physician's name	Phone number
Insurance company	Policy number
Allergies/Special health considerations	

Medication(s) taken regularly

➔ I do \_\_\_\_/do not \_\_\_\_ (initial one) give permission for Papahana Kuaola to use photographs and video recordings taken of myself, my child(ren), and/or minors in my care on the specified field trip date(s) for its non-profit work.

**AUTHORIZATION**

I give permission for myself, my child(ren), and/or minors in my care to participate in programming on the specified field trip date(s). I understand and acknowledge that participation involves inherent risks of injury. I release the landowner(s), Papahana Kuaola, its staff, and its Board of Directors from liability in case of an accident during the program, as long as normal safety procedures have been followed. I authorize all medical and surgical treatment as may be performed or prescribed by the attending physician and/or paramedics. I waive my rights to informed consent of treatment, only in the event that I or emergency contacts (listed above) cannot be reached. My signature below indicates that I have read, understood, and freely signed this form.

Parent/Guardian or Adult Participant's PRINTED NAME and SIGNATURE	DATE
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