

**MEDICAL WAIVER AND EMERGENCY INFORMATION
FOR PARTICIPANTS IN AQUARIUM PROGRAMS**

I sign this form and the accompanying Agreement to Waive and Release All Claims in consideration for permission by Metro Parks Tacoma-Point Defiance Zoo & Aquarium for the participant named below to participate in an Eye to Eye Shark Dive program. I agree that all of the terms of the Agreement shall apply to any claims relating to the participation of myself or the minor named below in the program. This includes (but is not limited to) my agreements to waive and release all claims and to indemnify and hold the Metro Parks Tacoma-Point Defiance Zoo & Aquarium and its representatives harmless against any claims. If completing this for a minor's participation, I affirm that I am the parent or guardian of the minor named below and have the legal capacity and authority to act on his or her behalf.

I understand that Aquarium will take reasonable precautions to prevent accidents, administer simple first aid for all minor injuries, and call parents and/or a doctor whenever necessary. I am aware that there are risks to participation in the program, and I voluntarily consent to the participation of myself or the minor in the program.

I confirm that the participant is in stable health, and that the information I provide below about the participant's medical history is accurate to the best of my knowledge. I hereby give my consent to representatives of the Aquarium to provide all emergency medical or dental care prescribed by a duly licensed health care provider. I understand that care may be given under whatever conditions are necessary to preserve the well-being, limb or life of the participant.

Name of Participant: _____ **Age:** _____ **date of birth:** _____

Doctor's Name and Telephone Number: _____ (____) _____

Participant Medical History Questionnaire: Conditions listed are not necessarily disqualifying for participation, but may require alterations to the program, or consultation with the participant's physician prior to participation.

- | Yes/No | Yes/No | Yes/No |
|--|--|--|
| <input type="checkbox"/> <input type="checkbox"/> Currently have a cold or congestion | <input type="checkbox"/> <input type="checkbox"/> A history of respiratory disease | <input type="checkbox"/> <input type="checkbox"/> Amputee/absence of any limb |
| <input type="checkbox"/> <input type="checkbox"/> Recent or current ear infection | <input type="checkbox"/> <input type="checkbox"/> Current asthma, emphysema, tuberculosis | <input type="checkbox"/> <input type="checkbox"/> Allergic reactions (Latex drysuit seals, shellfish etc...) |
| <input type="checkbox"/> <input type="checkbox"/> History of sinus problems/bloody nose | <input type="checkbox"/> <input type="checkbox"/> Currently prescribed an inhaler
(Prescribed inhalers MUST be brought to the program) | <input type="checkbox"/> <input type="checkbox"/> Recently had an operation or illness |
| <input type="checkbox"/> <input type="checkbox"/> Recurrent ear problems, ear tubes, ear disease or surgery | <input type="checkbox"/> <input type="checkbox"/> Diabetes - Blood sugar level before dive ok? YES/NO | <input type="checkbox"/> <input type="checkbox"/> Currently taking medications that carry a warning about any impairment of physical or mental abilities |
| <input type="checkbox"/> <input type="checkbox"/> Nervous system disorder | <input type="checkbox"/> <input type="checkbox"/> Recurrent back problems, back or spinal injuries/surgery | <input type="checkbox"/> <input type="checkbox"/> Currently pregnant |
| <input type="checkbox"/> <input type="checkbox"/> Behavioral health, mental or psychological disorders (including ADD, ADHD) | <input type="checkbox"/> <input type="checkbox"/> Under the care of a physician or have chronic illness | <input type="checkbox"/> <input type="checkbox"/> History of or currently a smoker |
| <input type="checkbox"/> <input type="checkbox"/> History of heart conditions | | <input type="checkbox"/> <input type="checkbox"/> Alcohol consumption or recreational drug use within the last 8 hours? |
| <input type="checkbox"/> <input type="checkbox"/> High blood pressure | | <input type="checkbox"/> <input type="checkbox"/> Other (please note below) |
| <input type="checkbox"/> <input type="checkbox"/> History of seizures, dizziness, or fainting | | |

Explanation of any relevant condition(s):

I understand that past and present medical conditions may contradict participation in this activity as well as elevate the risk of injuries, including but not limited to, pressure related injuries affecting the lungs, sinuses and ears, drowning, panic and other serious injury or death.

Two Emergency contacts (names and telephone numbers):

Name: _____ Phone: (____) _____ Name: _____ Phone: (____) _____

Participant Signature: _____ **Date:** _____

If Participant is a minor:

Name: _____ Telephone: (____) _____
Parent, Legal Guardian or Authorized Representative During the program

Signature: _____ Date: _____
Parent, Legal Guardian or Authorized Representative