



Please complete the following information about your child (18 or under) for Washington FEAST Event: Kyle Dine Tween/Teen event – Aug 22, 2009

Participant's name _____ Female ___ Male ___
Last First

Address _____

_____ City State Zip

Home phone _____ Mother's work phone _____

Father's work phone _____

Grade in September _____ Age _____

School: _____ Email (optional): _____

Would you like to be included on email announcements for future Tween/Teen events? Y N

Parent/Guardian name(s) _____

Phone where parent/guardian can be contacted during event: _____

Person to notify in emergency if parent cannot be reached:

Name _____ Relationship _____

Home Phone _____ Work Phone _____

Address _____

Secondary contact:

Name _____ Relationship _____

Home Phone _____ Work Phone _____

Address (optional) _____

**CONSENT OF PARENT OF GUARDIAN MUST BE FILLED OUT
FOR EACH CHILD WHO IS PARTICIPATING**

I, _____, as parent/guardian having legal custody of _____, who is voluntarily enrolled as a participant in the Kyle Dine Tween/Teen Event, understand that Washington FEAST programs involve inherent risk and possible injury because of the nature of the activity, even when conducted in a safe manner. I give permission for her/him to attend this FEAST event and participate in all phases of the program. I understand and accept the risks involved. Washington FEAST, their Board of Directors, Officers and volunteers shall in no way be held liable for any accident or injury in any way received by _____ (name of child) on account of or while engaged in this event except for injury due to negligence of the Washington FEAST, its board, officers and volunteers. I understand that every effort will be made to contact me if my child needs emergency medical/surgical treatment, but if it is impractical to do so, **I HEREBY GIVE PERMISSION** and authorize all medical, surgical, diagnostic, and hospital care or procedures which may be performed or prescribed for my child by a licensed physician or hospital when efforts to contact me are unsuccessful, and when deemed immediately or advisable by the physician to safeguard my child's health.

We further agree that Washington FEAST board, officers, and employees/volunteers shall not be responsible for payment of any bills rendered for medical services as a result of accidents, injuries, or illness. Each participant must provide evidence that he or she has health insurance coverage during the event period. Parents are responsible for reviewing their own individual or group health care plans in regards to coverage details and agree to assume the cost of any uninsured medical expenses due to the application of deductibles or plan coverage limitations.

Date _____ Parent/Guardian Signature _____

Please complete the following information:

Health Care Plan Insurer _____

Individual or Group Plan Number _____

Please list any food, bee sting or latex allergies that may require the use of epinephrine:

REQUIRED: Please provide EPINEPHRINE AUTOINJECTOR and other medication and FOOD ALLERGY ACTION PLAN and/or ASTHMA ACTION PLAN signed by parent or doctor with a PICTURE OF THE PARTICIPANT. It is preferred that each participant self-carry their own anaphylaxis and asthma rescue medicine.

I also give permission for my child to be photographed, and allow Washington FEAST to release said pictures for publicity purposes.

Date _____ Parent/Guardian Signature _____

Washington FEAST, 2400 NW 80th St. Box 315 Seattle WA 98117

www.wafeast.org