WILD ROOTS FOREST SCHOOL
Wildrootsschool.org / 805.570.3087

Child's Name: _____

Parent/Guardian's Name: _____
Full Home address:
_____

Emergency Medical Release

As the parent or authorized representative, I hereby give consent to Wild Roots along with its representatives, as agents of the undersigned, to obtain all emergency medical or dental care prescribed by a duly licensed physician, osteopath, or dentist for _____.
child's name

This care may be given under whatever conditions are necessary to preserve the life, limb or well being of the child named above. The undersigned also releases Wild Roots, and its agents, from all claims which may develop or accrue to me, or the minor for whom this authorizations intended to benefit, on account of, or reason by of, any injury, loss, or damage which may be suffered by me or the minor as a result of the exercise of this consent, and I hereby assume and accept the full risk and danger of any injury, hurt or damage that may occur as a result of the use of exercise of this consent.

Parent/Guardian Signature_____

Date_____

_____

Media Release

I, _____ , hereby give and grant to Wild Roots the right to use my/my child's name, image, likeness, and/or voice in still photos, slides, video productions, internet, radio and/or television coverage, to you, your licensees, successors, and assigns, in connection with the production, exhibition, distribution, advertising, and/or otherwise for the purpose of promoting Wild Roots and its programs.

Parent/Guardian Signature_____

Date_____