



RIVER LEGACY  
LIVING SCIENCE CENTER

**Student Information**

Child's Full Name \_\_\_\_\_ ( \_\_\_\_\_ )  
Last First Middle name child goes by

Date of Birth \_\_\_\_\_  Male  Female Child lives with  Mom  Dad  Other \_\_\_\_\_

Is a language other than English spoken in the home?  Yes  No Specify \_\_\_\_\_

Current Age/Grade \_\_\_\_\_ School \_\_\_\_\_

**Parent/Guardian Information**

Parent/Guardian #1 \_\_\_\_\_  Mom  Dad  Other Cell \_\_\_\_\_

Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Email \_\_\_\_\_ SS#(last 4 digits) \_\_\_\_\_

\*\*Required for Nature School Security

Work Phone \_\_\_\_\_ Employer \_\_\_\_\_

Parent/Guardian #2 \_\_\_\_\_  Mom  Dad  Other Cell \_\_\_\_\_

Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Email \_\_\_\_\_ SS#(last 4 digits) \_\_\_\_\_

\*\*Required for Nature School Security

Work Phone \_\_\_\_\_ Employer \_\_\_\_\_

**Child Wellness Information**

Does your child have disabilities, special needs or illness that we should be aware of?  Yes  No Specify \_\_\_\_\_

Is your child allergic (stings, foods, medications)?  Yes  No Specify \_\_\_\_\_

Is your child asthmatic?  Yes  No Specify \_\_\_\_\_

Does your child see well?  Yes  No Specify \_\_\_\_\_

Does your child hear well?  Yes  No Specify \_\_\_\_\_

***Form Continues***

**For Office Use Only**

**NS** Class \_\_\_\_\_ Day \_\_\_\_\_ Start Date \_\_\_\_\_

**AS**  **HS** Class \_\_\_\_\_ Club # \_\_\_\_\_

**SC** Session \_\_\_\_\_ Class \_\_\_\_\_ AM / PM

Session \_\_\_\_\_ Class \_\_\_\_\_ AM / PM

**Authorizations**

Who should be notified if we cannot reach you in case of sickness or accident?

Name	Address, City, Zip	Phone	Relationship
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

My child has permission to leave with the following people (please include yourself and spouse, if applicable)

Name	Phone	Relationship
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

**Under no circumstances will any child be dismissed to anyone other than one of the adults listed above.  
Please inform your child's teacher if you need to make changes to this list.**

**Please initial below to signify your response to the following statements:**

I hereby give my permission for my child to be transported & supervised in an emergency situation.

\_\_\_\_\_ I agree (*initial*)

I hereby give my permission for my child to participate in water table play.

\_\_\_\_\_ I agree (*initial*)

I have read the cancellation and refund policy(ies) included on River Legacy's online registration site for the program(s) that I am registering for and accept these terms.

\_\_\_\_\_ I agree (*initial*)

I give my permission for my child to be photographed or videotaped during program and class activities. I understand that these photos or videos may be used to promote River Legacy and its Education Programs.

\_\_\_\_\_ Yes \_\_\_\_\_ No (*initial*)

I give my permission for my child's name and address to be included on a class roster distributed to Nature School families in my child's class. I understand that River Legacy Foundation will not release this roster for general distribution.

\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Not a Nature School student (*initial*)

**Authorization for Participation and Medical Consent**

I am the natural parent, guardian or managing conservator of \_\_\_\_\_, a minor. I hereby give my permission for my child to participate in all River Legacy program activities, including nature walks. In the event I cannot be personally contacted, I do hereby grant authority to River Legacy Foundation, its agents, officers, employees, representatives and volunteers to consent to medical treatment and transportation as necessary, if required by the minor child.

This authorization is for the purpose of securing benefits for the health and welfare of my minor child and expressly includes the authority to sign releases for physicians and hospitals or medical facilities, as selected by River Legacy Staff, who may render medical care and service. I assume liability for payment of all such professional treatment, care, drugs and other services for my minor child.

I agree to indemnify and hold harmless River Legacy Foundation, its agents, officers, employees, representatives, and volunteers from any and all responsibility owed to the child, the parent or their legal representatives, heirs and assigns from any and all claims, demands, actions, judgments, causes of action or damages that the parent or child ever had or may have, whether caused by the negligence of River Legacy Foundation, or their agents, officers, employees, representatives, or volunteers while the child is participating in the activities of River Legacy Foundation.

Name \_\_\_\_\_ Date \_\_\_\_\_

**By typing your name above, you are authorizing your agreement to the terms of this statement.**