



# Wonderful Outdoor World

La Ciudad de Los Angeles Departamento de Recreacion y Parques

## APLICACION DE INSCRIPCIÓN

Niños y Niñas: 8 a 13 Años de Edad

**Nota:** Las aplicaciones seran aceptadas en orden de quien llegue primero.

Nombre del Participante \_\_\_\_\_

Circule uno: Femenina o Masculino Edad \_\_\_\_\_ Fecha de Nacimiento \_\_\_\_\_

Domicilio \_\_\_\_\_ Apt# \_\_\_\_\_

Ciudad \_\_\_\_\_ Estado \_\_\_\_\_ Código Postal \_\_\_\_\_

Padres/Guardián \_\_\_\_\_ Relación \_\_\_\_\_

Teléfono de Casa \_\_\_\_\_ Teléfono del Trabajo \_\_\_\_\_

Lea ud. la informacion en Inglés incluido en este paquete para confirmar los obligaciones legales que existen para participar en este programa y devolver a nosotros firmado que las polizas son entendidas claramente. Firme abajo para significar que ud. he leído la informacion de WOW en Inglés. Yo he leído y entiendo la registracion y polizas incluidos en este paquete.

### **CONSENTIMIENTO MENOR, DE INDEMNIZACIÓN Y LIBERACIÓN DE ACUERDO Y AUTORIZACIÓN PARA REPRODUCIR IMAGEN FÍSICA Y VOZ**

Yo entiendo que WOW, Wonderful Outdoor World ("WOW"), programas (denominados colectivamente "Programa") son programas de la Ciudad de Los Angeles a través de su Departamento de Recreación y Parques (la "Ciudad") para los niños que residen en la Ciudad . La ciudad no podrá funcionar si sus limitados recursos se ven amenazados por los pleitos. La Ciudad de la capacidad de proporcionar el Programa depende de una cierta cantidad de alojamiento y la comprensión de sus participantes. Por ello estoy de acuerdo para asumir la responsabilidad de la participación de mi hijo en el programa de WOW, como se refleja en este acuerdo. He leído la Hoja de Información WOW. Yo entiendo que cada campista se espera que participen en todas las actividades del campamento. Yo entiendo que el Director de el programa debe tener una re copia de la Tarjeta de Salud del participante, actualizado recientemente, en la oficina de WOW. He leído y entiendo el registro y la poliza de reembolso.

X \_\_\_\_\_  
Firma del Padre/Guardián

\_\_\_\_\_  
Fecha

FOR AND IN CONSIDERATION of my child's participation in and use of any of the premises, facilities and/or equipment of any City Program, to the fullest extent permitted by applicable laws I DO HEREBY, for myself and my participating child, agree as follows:

1. My Child's participation in any program means that I have inspected the program to the extent I believe is necessary for careful consideration and that, although I ACKNOWLEDGE THAT THERE MAYBE A RISK OF SEROUS INJURY (KNOWN OR UNKNOWN) IN ANY PROGRAM, I have determined that it is reasonably safe and suited for my child.
2. I consent to my child's participation in any City program and my child's assumption of the risks of that participation.

Name of Participating Child: \_\_\_\_\_ (Please Print)

3. I have been made aware that any Program may be filmed and be used for promotional purposes by WOW, the City or other sponsors of WOW (the "Other WOW Sponsors"). I HEREBY IRREVOCABLY GRANT to the City and the Other WOW Sponsors, their respective affiliated and related companies and any third parties they may authorize, the right to photograph my child and make recordings of my child's voice at any Program, and the right to use pictures and other reproductions of my child's physical likeness (as it may appear in any photography and/or motion picture, film, Web site or tape) and recordings of my child's voice in any medium in any form, without regard to whether any financial benefit accrues to any such user.
4. I RELEASE, COVENANT NOT TO SUE AND AGREE TO INDEMNIFY AND HOLD HARMLESS the City, WOW, the Other WOW Sponsors and their respective related, affiliated or subsidiary companies, and the officers, directors, employees or agents of each (collectively, the "Releases"), of and from any and all claims, causes of action, damages, liabilities or expenses (collectively, "Claims"), known or unknown, existing now or in the future, that my child or I may now or hereafter have against the Releases, arising in any way from my child's participation in any Program (including the use of my child's physical likeness or voice and reproductions or recordings thereof), and regardless of any fault or negligence on the part of the Releases.
5. I HEREBY EXPRESSLY WAIVE AND RELINQUISH ALL RIGHTS AND BENEFITS AFFORDED BY CALIFORNIA CIVIL CODE SECTION 1542 and do so understanding and acknowledging the significance of this specific waiver of Section 1542. Section 1542 states as follows:
  - a. A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS WHICH THE CREDITOR DOES NOT KNOW OR SUSPECT TO EXIST IN HIS FAVOR AT THE TIME OF EXECUTING THE RELEASE, WHICH IF KNOWN BY HIM MUST HAVE MATERIALLY AFFECTED HIS SETTLEMENT WITH THE DEBTOR.
6. I ASSUME FULL RESPONSIBILITY FOR, AND ALL RISK OF any bodily injury, death or property damage suffered by my child or myself for any reason due to my child's participation in any program.
7. If my child becomes injured or ill while participating in any Program, I hereby authorize an adult representative of the City to administer, or to cause and consent to the administration of, whatever first aid, medical care, dental care or other treatment and medications as may be necessary under the circumstances, including treatment by a physician, dentist or hospital, although I hereby acknowledge that the City has no obligation to do so. I further acknowledge that the City does not endorse the services of any physician or hospital that may treat my child. I understand that I will be obligation to pay any such costs.
8. I have carefully read this agreement, and I know and understand what it means. My signature below is my own free act and I intend it to be legally binding on me. This agreement constitutes the entire understanding between the City and myself regarding the subject matter hereof and supersedes any prior statements, agreements or representations, whether written or oral, regarding that subject matter.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent / Guardian Name (please print): \_\_\_\_\_

Ciudad de Los Angeles Departamento de Recreacion y Parques  
WONDERFUL OUTDOOR WORLD

**FORMA DE HISTORIA DE SALUD**

**Nota:** Si algo sucediera al participante que modificará la información de su historia de salud; favor de notificar al Director de WOW inmediatamente antes de que ud. llegada a campiar Un padre o guardián de este participante deberá llenar este formulario.

Nombre de Participante \_\_\_\_\_

Circule Uno: Femenino o Masculine Edad \_\_\_\_\_ Fecha de Nacimiento \_\_\_\_\_

Domicilio \_\_\_\_\_ Apt # \_\_\_\_\_

Ciudad \_\_\_\_\_ Estado \_\_\_\_\_ Código Postal \_\_\_\_\_

Nombre de un Miembro Familiar \_\_\_\_\_ Teléfono \_\_\_\_\_

Nombre del Doctor \_\_\_\_\_ Teléfono \_\_\_\_\_

El participante ha tenido el siguiente (por favor marque):

- |   |  |                                       |
|---|--|---------------------------------------|
| <input type="checkbox"/> Varicela               | <input type="checkbox"/> Amigdalitis               | <input type="checkbox"/> Otros: _____ |
| <input type="checkbox"/> Sarampión              | <input type="checkbox"/> Apendicitis               |                                       |
| <input type="checkbox"/> Sarampión Alemán       | <input type="checkbox"/> Asma                      |                                       |
| <input type="checkbox"/> Fiebre Reumática       | <input type="checkbox"/> Fiebre de Heno            |                                       |
| <input type="checkbox"/> Escarlatina            | <input type="checkbox"/> Los frecuentes Resfriados |                                       |
| <input type="checkbox"/> Difteria               | <input type="checkbox"/> Dolores de Cabeza         |                                       |
| <input type="checkbox"/> Problemas del Corazón  | <input type="checkbox"/> Alojamiento Humectantes   |                                       |
| <input type="checkbox"/> Paperas                | <input type="checkbox"/> Desmayo                   |                                       |
| <input type="checkbox"/> Problemas de Sinusitis | <input type="checkbox"/> Estreñimiento             |                                       |
| <input type="checkbox"/> Infección del oído     | <input type="checkbox"/> Malestar Estomacal        |                                       |
| <input type="checkbox"/> Sangrado por la Nariz  | <input type="checkbox"/> Erupción Cutánea          |                                       |

Dar el año de la última vacunación o dosis adicional:

Paperas Tetanus \_\_\_\_\_  
Difteria de Sarampión \_\_\_\_\_  
Tos Ferina Sarampión Alemán \_\_\_\_\_  
Poliomielitis \_\_\_\_\_

Otras Alergias (especificar)

- |   |       |
|---|-------|
| <input type="checkbox"/> Peaduras de Abeja, Mosquitos       | _____ |
| <input type="checkbox"/> Comida                             | _____ |
| <input type="checkbox"/> Medicamentos                       | _____ |
| <input type="checkbox"/> Asma (o fiebre del heno)           | _____ |
| <input type="checkbox"/> Las Lesiones o Enfermedades Graves | _____ |

El participante ha recibido tratamiento médico en el último año?

Círculo Uno: SI NO Fecha del Tratamiento: \_\_\_\_\_

Razon/Motivo: \_\_\_\_\_

El participante esta tomando alguna medicina ahora? \_\_\_\_\_

Medicamentos recetados tienen que ser en original contenedores de la farmacia (no se introduce ninguna modificación). El Director del programa WOW debe ser notificado si hay una medicina que el participante necesita llevar consigo. Tiene que firmar la forma en Inglés y devolverla para que su hijo/a reciba atención médica si es necesario durante la duración de el programa.

**Request for Medication to be Given during Camp**

*(To be completed by parent or guardian)*

I request that my child, \_\_\_\_\_, be given/allowed to take the following prescribed medicine(s) while at camp. I understand that WOW will only give the medicine described below according to the time, dosage and frequency indicated on the pharmacy label of the medicine bottle unless I have a written prescription or letter addressed to WOW and signed by my child's doctor. This letter must specifically state the time, dosage and frequency of each named medicine.

Name of Medicine: \_\_\_\_\_ Dose Prescribed: \_\_\_\_\_

Time(s) Given: \_\_\_\_\_ Date Prescribed: \_\_\_\_\_

Reasons for taking Medicine: \_\_\_\_\_

Name of Medicine: \_\_\_\_\_ Dose Prescribed: \_\_\_\_\_

Time(s) Given: \_\_\_\_\_ Date Prescribed: \_\_\_\_\_

Reasons for taking Medicine: \_\_\_\_\_

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**AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR AT AUTHORIZED HOSPITAL IN CASE OF EMERGENCY ILLNESS OR ACCIDENT**

I (We), the undersigned parent(s) of \_\_\_\_\_, a minor do hereby authorize the directors of WOW Camping Program as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provision of the Medical Practice Act on the medical staff of a licensed hospital whether such diagnosis or treat is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but it is given to provide authority and power on the part of aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable. This authorization shall remain effective through the conclusion of the event, unless sooner revoked in writing and delivered to said agent(s).

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**FORMA DE FIRMA DE AUTORIZACIÓN**

Nombre de Participante \_\_\_\_\_

En caso de que yo no este presente, una de las personas mencionadas tendran el permiso de firmar para llevar o sacar mi hijo o hija a la hora asignada.

Nombre \_\_\_\_\_ Relacion al Participante \_\_\_\_\_ Teléfono \_\_\_\_\_

Nombre \_\_\_\_\_ Relacion al Participante \_\_\_\_\_ Teléfono \_\_\_\_\_

Nombre \_\_\_\_\_ Relacion al Participante \_\_\_\_\_ Teléfono \_\_\_\_\_

Nombre \_\_\_\_\_ Relacion al Participante \_\_\_\_\_ Teléfono \_\_\_\_\_

Nombre de la persona o personas especificamente que NO podran firmar para sacar al niño o niña participando en el programa:

\_\_\_\_\_

Firma de Padre/Guardian \_\_\_\_\_ Fecha: \_\_\_\_\_

Si usted quiere dejar que su hijo o hija camine a casa, por favor complete esta forma (Marque y Firme abajo):

( ) Yo autorizo que mi hijo o hija camine a casa.

Firma de Padre/ Guardián \_\_\_\_\_ Fecha: \_\_\_\_\_