Beyond Blindness

Participant Registration Form

Social Society

Student Information					
Child's Name:					
Date of Birth:				**Gender:**	M ☐ F ☐
Mailing Address:				**Apt #**	
City:		**State:**		**Zipcode:**	
Primary Language at home:					
Parent/Guardian Information					
Parent Name:				**Relationship:**	
Phone Number:		**Email:**			
Emergency Contact Information					
Name:		**Relationship:**		**Cell:**	
Name:		**Relationship:**		**Cell**	
Name:		**Relationship:**		**Cell:**	
Student School Information					
School Name:				**Grade:**	
School District:				**Teacher:**	

Student Medical Information
Does your child have a vision or medical diagnosis?
Y ☐ N ☐ if yes, please explain:
Does your child have any health problems?
Y ☐ N ☐ if yes, please explain:
My child is currently taking medication(s)
Y ☐ N ☐ if yes, please list medications:
Does your child have any known allergies?
Y ☐ N ☐ if yes, please list allergies and known reactions:
Is there any additional health/medical information you would like to share?
Is there any specific skills or goals you would like for us to work on? What do you hope to achieve through participation in this program?

Signature of Parent/Legal Guardian Date

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Consent for Use of Video Tape, Digital Images, and Photographs

Participant Information

- **Participant Name:** _____
- **Date of Birth:** _____ ☐ Participant is **18 years or older**
- **Program/Group Name:** _____

Photo, Video & Media Permission

I hereby grant permission to Beyond Blindness to photograph, record, or otherwise capture the likeness, image, voice, or appearance of myself and/or my minor child or legal ward during participation in Beyond Blindness programs, activities, and community outings.
I understand that these images or recordings may be used for educational, informational, promotional, fundraising, and public awareness purposes, including but not limited to print materials, websites, social media, presentations, and reports.
I understand that no compensation will be provided and that all images and recordings become the property of Beyond Blindness.

Opt-Out (optional)

☐ I **do not** grant permission for photo, video, or media use.

Signature & California Minor Consent

By signing below, I certify that I am the participant **18 years of age or older**, or the **parent or legal guardian** of the minor participant named above, and that I have legal authority to grant or deny this permission.

Participant Signature (if 18+):
_____ **Date:** _____

Parent/Guardian Name (print): _____

Parent/Guardian Signature:
_____ **Date:** _____

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Hold Harmless Agreement

Permission, Release & Assumption of Risk

I understand that participation in Beyond Blindness community outings may involve travel and activities outside of Beyond Blindness facilities and may include risks inherent to off-site activities, including but not limited to transportation-related risks, environmental conditions, and interaction with members of the public.

In accordance with California law, I, on behalf of myself and/or my minor child or legal ward, knowingly and voluntarily assume all risks associated with participation.

To the fullest extent permitted by California law, I hereby release, waive, discharge, and hold harmless Beyond Blindness, its officers, directors, employees, agents, volunteers, contractors, insurers, and partnering organizations from any and all claims, demands, damages, losses, actions, or causes of action arising out of or related to participation, including transportation to and from activities, except to the extent such claims arise from gross negligence or willful misconduct as defined under California law.

If any portion of this agreement is held invalid, the remainder shall continue in full force and effect.

Medical Consent & Emergency Treatment Authorization

In the event of an emergency, I authorize Beyond Blindness staff and/or volunteers to obtain emergency medical treatment for myself and/or my minor child or legal ward, including first aid, emergency transportation, and treatment by licensed medical professionals. I understand reasonable efforts will be made to contact the emergency contact listed above.

I agree to assume financial responsibility for any medical care or treatment rendered.

Signature & California Minor Consent

By signing below, I certify that I am the participant **18 years of age or older**, or the **parent or legal guardian** of the minor participant named above, and that I have legal authority to grant this permission.

I have read and understand this consent, release, assumption of risk, and medical authorization and agree to its terms.

Participant Signature (if 18+):

_____ **Date:** _____

Parent/Guardian Name (print): _____

Parent/Guardian Signature:

_____ **Date:** _____