



# Youth Programs Agreement Form

To confirm a party please fill out this form (**one for each attendee**) front and back and return via email to [heducation@hswestmi.org](mailto:heducation@hswestmi.org) or fax (616) 453-5752.

**Please note HSWM no longer accepts checks.**

**Child's name:** \_\_\_\_\_ **Child's Age:** \_\_\_\_\_

**Parent's Name:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Phone number:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_ **Allergies:** \_\_\_\_\_

**Program Attending:** \_\_\_\_\_

I certify that I have the authority to enter into this agreement on behalf of my child and release and waive any claims that I or my child may have against the HSWM with respect to any loss, injury, illness, damage or death occurring to my child while he/she is in the custody and care of HSWM as well as any related claims that I may have. I agree to indemnify and hold harmless the HSWM from and against any and all liability and costs (including attorney fees) related to any such claim asserted against HSWM by or on behalf of my child or me. I certify that if my child has any physical, emotional or mental limitations they will be noted so that the appropriate attention/accommodations can be given to my child.

I agree that this release, waiver of liability and indemnification agreement is intended to be as broad and inclusive as permitted by the laws of the state of Michigan, and that if any portion thereof is held invalid, it is agreed that the balance shall notwithstanding continue in full legal force and effect.

In event of accident or injury to my child, I authorize the HSWM to make whatever transportation, diagnosis and/or treatment arrangements as they, in their sole discretion, deem to be appropriate in the circumstances. I agree that my insurance or I personally will be liable for any costs incurred for the transportation, diagnosis and/or treatment of my child. I understand that the HSWM will make a reasonable effort to contact me at the phone number(s) listed below and to honor any other health care requests indicated below but that the transportation, diagnosis and/or treatment of my child will proceed whether or not I can be contacted.

I grant HSWM the right to use my name, portrait, photograph, video segment or other image, and those of any minor named below, on whose behalf I am signing, for marketing, public relations and/or educational purposes. I grant HSWM the right to use the name or image described above in print, video and/or electronic media. I understand that HSWM retains all rights to use, publish or distribute the portraits, photographs, video segments or other images and has the right to do so without seeking any further permission from me or providing me any royalty. I ask that the HSWM use reasonable efforts to give me advance notice of any such use, but such notification is not a condition to HSWM's use or publication of my name or image for marketing, public relations and/or educational purposes.

I understand that HSWM cannot guarantee the amount of animal time provided due to ensuring the safety of guests as well as the animals in HSWM's care.

**Signature and Date:** \_\_\_\_\_

# Payment Form

Note: HSWM no longer accepts checks

Total amount enclosed \$ \_\_\_\_\_

Select payment method:

Visa \_\_\_\_\_ Mastercard \_\_\_\_\_ Cash \_\_\_\_\_

Credit Card Number: \_\_\_\_\_

Exp. Date: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Security Code (on back of card): \_\_\_\_\_

Authorized Signature and Date: \_\_\_\_\_