



Florida Fish  
and Wildlife  
Conservation  
Commission

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**EYCC 1-1**

**2014 Everglades Youth Conservation Camp  
JUNIOR COUNSELOR HEALTH HISTORY  
AND PARENT'S AUTHORIZATION FORM**



Florida Youth Conservation  
Centers Network

**PARENT/GUARDIAN: PLEASE FILL OUT AND HAVE THIS FORM NOTARIZED.**

Camper Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
Last First Middle (these are for demographics only)

Home Address \_\_\_\_\_  
Street Address City State Zip

Parent/Guardian \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Home Address \_\_\_\_\_  
(if different from above) Street Address City State Zip

Business Address \_\_\_\_\_  
Street Address City State Zip

**IF NOT AVAILABLE IN AN EMERGENCY, NOTIFY:**

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Home Address \_\_\_\_\_  
(if different from above) Street Address City State Zip

2. Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Home Address \_\_\_\_\_  
(if different from above) Street Address City State Zip

**INSURANCE INFORMATION**

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name \_\_\_\_\_ Group# \_\_\_\_\_

➤A photocopy of the front and back of your health insurance card must be attached to this form.

**IMPORTANT – THIS BOX MUST BE COMPLETE FOR ATTENDANCE**

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Sworn to and subscribed before me this

\_\_\_\_\_ Day of \_\_\_\_\_ 20\_\_\_\_\_  
Signature of Parent or Guardian Date

Notary Public \_\_\_\_\_

My Commission expires \_\_\_\_\_

## HEALTH HISTORY

The following information must be filled in by the parent/guardian. The intent of this information is to provide camp health care personnel background information to provide appropriate care. Keep a copy of the completed form for your records. Provide complete information so that the camp can be aware of your needs.

YES	NO	CONDITION	EXPLAIN
<input type="checkbox"/>	<input type="checkbox"/>	Recent injury, illness or infectious disease	
<input type="checkbox"/>	<input type="checkbox"/>	Chronic or recurring illness/condition	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma Last attack: (MM/YY) _____	
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (high blood pressure)	
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease/heart attack/chest pain/heart murmur	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	
<input type="checkbox"/>	<input type="checkbox"/>	Lung/respiratory disease	
<input type="checkbox"/>	<input type="checkbox"/>	Ear/sinus problems	
<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches	
<input type="checkbox"/>	<input type="checkbox"/>	Frequent sore throats or colds	
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal/digestive problems (e.g., stomach upsets,	
<input type="checkbox"/>	<input type="checkbox"/>	Muscular/skeletal condition (e.g., back pain)	
<input type="checkbox"/>	<input type="checkbox"/>	Skin problems (e.g., itching, rash, acne)?	
<input type="checkbox"/>	<input type="checkbox"/>	Excessive fatigue or shortness of breath with exercise	
<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells/Dizziness during or after exercise	
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures Last seizure: (MM/YY) _____	
<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorders (e.g., sleep walking, sleep apnea)	
<input type="checkbox"/>	<input type="checkbox"/>	History of bed-wetting	
<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problems (women only)	
<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder	
<input type="checkbox"/>	<input type="checkbox"/>	Ever been hospitalized?	
<input type="checkbox"/>	<input type="checkbox"/>	Surgery Last surgery: (MM/YY) _____	
<input type="checkbox"/>	<input type="checkbox"/>	Serious injury or knocked unconscious	
<input type="checkbox"/>	<input type="checkbox"/>	Blood disorders (e.g., Sickle cell disease, clotting disorder)	
<input type="checkbox"/>	<input type="checkbox"/>	Attention Deficit Disorder	
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric/psychological and emotional difficulties	
<input type="checkbox"/>	<input type="checkbox"/>	Behavioral/neurological disorders	
<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis in the past 12 months?	
<input type="checkbox"/>	<input type="checkbox"/>	Been sick in the last week?	
<input type="checkbox"/>	<input type="checkbox"/>	Wear eye glasses, contacts or protective eyewear?	
<input type="checkbox"/>	<input type="checkbox"/>	Have an orthodontic appliance being brought to camp?	

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware. (use additional sheet if necessary)

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Is your child **DIABETIC**? ☐ YES ☐ NO If yes, How often is blood sugar checked? \_\_\_\_\_

Insulin? ☐ YES ☐ NO Type \_\_\_\_\_ How often? \_\_\_\_\_

Correction dose? ☐ YES ☐ NO If so, order \_\_\_\_\_

Glucagon? ☐ YES ☐ NO Glucose tablets? ☐ YES ☐ NO

**\*Make sure to bring all supplies to the nurse at check-in.**

**SEVERE ALLERGIES** List all known allergies and what happens?

<input type="checkbox"/> <b>Medication Allergies (list)</b>  <input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Swelling (location _____) <input type="checkbox"/> Trouble breathing <input type="checkbox"/> Wheezing <input type="checkbox"/> Blue around mouth <input type="checkbox"/> Other _____ Does child have an EpiPen? YES / NO Did you send it to camp? YES / NO	<input type="checkbox"/> <b>Food Allergies (list)</b>  <input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Swelling (location _____) <input type="checkbox"/> Trouble breathing <input type="checkbox"/> Wheezing <input type="checkbox"/> Blue around mouth <input type="checkbox"/> Other _____ Does child have an EpiPen ? YES / NO Did you send it to camp? YES / NO	<input type="checkbox"/> <b>Insect Allergies (list)</b>  <input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Swelling (location _____) <input type="checkbox"/> Trouble breathing <input type="checkbox"/> Wheezing <input type="checkbox"/> Blue around mouth <input type="checkbox"/> Other _____ Does child have an EpiPen? YES / NO Did you send it to camp? YES / NO
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**Other allergies** (list) – include hay fever, animal dander, poison ivy, etc.

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**MEDICATIONS BEING TAKEN**

List ALL medications taken routinely (including over-the counter or nonprescription drugs). Bring enough medication to last the week. Keep in original packaging/bottle that identifies prescribing physician, name of medication, dosage and frequency of administration. **\*\* Medication will be given as written on Rx bottle. Be sure to bring medications with correct instructions.\*\***

☐ **This person takes NO medications on a routine basis**

<b>Med # 1</b> _____ Dosage _____ Time taken each day _____  Reason for medication _____  To be given at camp? <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>Med # 2</b> _____ Dosage _____ Time taken each day _____  Reason for medication _____  To be given at camp? <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>Med # 3</b> _____ Dosage _____ Time taken each day _____  Reason for medication _____  To be given at camp? <input type="checkbox"/> YES <input type="checkbox"/> NO
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**\*\*\*ALL medications MUST be given to camp nurse at check-in.  
Campers may not keep any medication in cabins.\*\*\***

**RESTRICTIONS** The following restrictions apply to this individual:

**Dietary**

<input type="checkbox"/> Does not eat red meat	<input type="checkbox"/> Does not eat pork	<input type="checkbox"/> Does not eat eggs
<input type="checkbox"/> Does not eat poultry	<input type="checkbox"/> Does not eat seafood	<input type="checkbox"/> Does not eat dairy products
<input type="checkbox"/> Other (describe) _____		

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**Explain any restriction to activity** (e.g., what cannot be done, what adaptations are necessary)

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**Physical activity**

Your child may participate in the following activities while at camp. Please check the ones they may NOT participate in and explain?

<input type="checkbox"/> Mud hike _____	<input type="checkbox"/> Fishing _____
<input type="checkbox"/> Swimming _____	<input type="checkbox"/> Archery _____
<input type="checkbox"/> Canoeing _____	<input type="checkbox"/> Campfire _____

**IMMUNIZATION HISTORY:** Required immunizations must be determined locally. Please record the date, month and year of basic immunizations and most recent booster doses.

Immunized?		Immunization (Circle all that apply)	Year of Basic Immunization	Date of Last Booster (MM/YY)	Had Disease?		Date (MM/YY)	
YES	NO				YES	NO		
<input type="checkbox"/>	<input type="checkbox"/>	DTaP/DT/Td	Diphtheria			<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>		Tetanus			<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>		Pertussis			<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	MMR/MMRV	Measles			<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>		Mumps			<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>		Rubella/German Measles			<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Varicela	Chicken pox			<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	IPV	Polio			<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	HepB	Hepatitis B			<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	HepA	Hepatitis A			<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	MCV	Meningitis			<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Hib	Haemophilus influenzae type B vaccine			<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	HPV	Human Papillomavirus			<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	BCG	Tuberculin			<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	TIV/LAIV	Flu			<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>		Other			<input type="checkbox"/>	<input type="checkbox"/>	

Name of Family Physician \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_

Name of Family Dentist/Orthodontist \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_

**FOR CAMP USE ONLY**

I have reviewed the person's health information described above.

Signature of EYCC Medical Supervisor \_\_\_\_\_

Printed \_\_\_\_\_ Title \_\_\_\_\_

Date \_\_\_\_\_



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**EYCC 2**

**2014 Everglades Youth Conservation Camp  
REQUIRED HEALTH CARE EXAM  
By Licensed Medical Personnel**



Florida Youth Conservation  
Centers Network

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

THIS EXAMINATION **MUST** BE PERFORMED WITHIN ONE YEAR OF ARRIVAL AT CAMP.

A documented physical exam, such as for sports, may be substituted if it contains the same information and has been administered within one year of arrival at Camp. Examination is for determining fitness to engage in strenuous camp activity.

I examined this individual on \_\_\_\_\_

Height _____	Weight _____	Blood Pressure _____	Eyes _____
Nose _____	Teeth _____	Throat _____	Heart _____
Ears _____	Lungs _____	Abdomen _____	Skin _____

In my opinion, the above applicant ☐ is ☐ is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Recommendations and Restrictions at Camp**

Treatment to be continued at camp \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications to be administered at camp (name, dosage, frequency) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any medically-prescribed meal plan or dietary restrictions \_\_\_\_\_  
\_\_\_\_\_

Description of any limitation or restriction on camp activities \_\_\_\_\_  
\_\_\_\_\_

Additional information for health care staff at the camp \_\_\_\_\_  
\_\_\_\_\_

**Signature of Licensed Medical Personnel** \_\_\_\_\_  
Printed \_\_\_\_\_ Title \_\_\_\_\_  
Phone \_\_\_\_\_ Date \_\_\_\_\_

**Screening Record** *FOR CAMP USE ONLY*

Date screened \_\_\_\_\_ Time \_\_\_\_\_

Meds Received \_\_\_\_\_  
\_\_\_\_\_

Current health needs identified \_\_\_\_\_  
\_\_\_\_\_

Observational notes \_\_\_\_\_  
\_\_\_\_\_

Screened By \_\_\_\_\_



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**EYCC 3**

**2014 Everglades Youth Conservation Camp  
PICK UP AUTHORIZATION  
OTC MEDICATION FORMS**



Florida Youth Conservation  
Centers Network

**Pick up Authorization**

Camper's Name: \_\_\_\_\_ Program/Cabin Number: \_\_\_\_\_

**Pick Up Release Authorization**

I give permission for the following people to pick up my child on Friday between 3:00 – 6:00 p.m., the last day of camp. I agree that I, or the person(s) I authorize, will check my child out with the camp administrator in the Dining Hall before leaving the grounds and I understand that I/they may be asked to show verification. \_\_\_\_\_ (Initial)

Please provide a pick-up password for your child: \_\_\_\_\_

List names and phone numbers of people including parent(s) permitted to pick-up your child: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian Signature (Signature verifies all initialed above)

Date

This form must be filled out. Even if you feel you are the only person that will be picking-up your camper, who would you send in case of an emergency.

**Permission to Administer Over-the-Counter Medication**

Do not bring over-the-counter medications unless your child has allergies to some medications or uses specific brands. Only bring vitamins if they are absolutely necessary. Please bring all medications (prescriptions, over-the counter and vitamins) when signing your child in at camp. **All must be in original containers.** All medications must be turned into the medical staff for distribution at the appropriate times each day.

By **initialing below** you are giving permission for first-aid certified staff and/or the designated medical staff to administer first-aid as well as simple over-the-counter medications for insect bites, stings, headaches, stomachaches, etc., as needed.

\_\_\_\_\_ The camp may administer any over-the-counter medication as deemed necessary by the medical staff or first-aid certified staff **or**

\_\_\_\_\_ The following over-the counter medications can be administered to my child: \_\_\_\_\_

\_\_\_\_\_ My child has no medication allergies I am aware of

\_\_\_\_\_ My child is allergic to the following medications: \_\_\_\_\_

\_\_\_\_\_ If my child forgets or loses his/her sunscreen or bug spray, the camp has my permission to apply any sunscreen or bug spray deemed necessary.

I give permission for first-aid staff and the designated medical staff at the Everglades Youth Conservation Camp to administer the above mentioned over-the-counter medications to my child. I will not hold the Everglades Youth Conservation Camp, Florida Youth Conservation Centers Network or Florida Fish and Wildlife Conservation Commission responsible in the event of a reaction to the medication administered as per my direction. \_\_\_\_\_ (Initial)

\_\_\_\_\_  
(Signature verifies all initialed above) Date Parent/Guardian Signature



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## EYCC 4

# 2014 Everglades Youth Conservation Camp JUNIOR COUNSELOR'S CODE OF CONDUCT



Florida Youth Conservation  
Centers Network

The staff of the Everglades Youth Conservation Camp is committed to providing a safe and enjoyable experience for your child; however, campers are also responsible to assist in these efforts. Parents are responsible to make sure their child brings the appropriate clothing and items to camp. ***You must review this CODE OF CONDUCT!***

### BEHAVIOR

1. Junior Staff must accept and get along with others. Put-downs, cuts, malicious teasing, practical jokes, etc., will not be tolerated from any camper.
2. Junior Staff will be sensitive to others in terms of race, religion, physical characteristics, regional differences and language. Ethnic or religious slurs or jokes will not be used.
3. Junior Staff must respect others and their property. Junior Staff will refrain from touching others in any harmful or inappropriate way.
4. Junior Staff will not use foul language. Use of curse words is offensive to many and unacceptable for children of the ages attending our camp.
5. Junior Staff will follow directions the first time they are given. Most of our directions are for the safety of campers and second chances may be too late.
6. Junior Staff are prohibited from bringing weapons, flammables or explosives into the camp. Violation of this policy is grounds for automatic dismissal.
7. The EYCC is a tobacco, alcohol and drug free workplace. Use and/or possession of tobacco, alcohol, drugs and/or any other substance defined as a drug or potentially dangerous are grounds for automatic dismissal.

### SAFETY

8. Junior Staff must wear closed-toe/closed-heel shoes at all times, except when participating in a water activity or showering. Water shoes are required for these activities.
9. Junior Staff must utilize the buddy system when traveling through the camp.
10. Junior Staff must pay attention to their surroundings and use care in all activities.
11. Junior Staff will adhere to all safety rules and regulations given for each activity he/she participates in while at camp.

### GENERAL

12. Junior Staff are expected to pack and bring only appropriate clothing as set forth on the Camper Supply List. Inappropriate clothing will not be worn at camp. Make sure the items listed, as not permitted, do not come to Camp.
13. We try to create an environment that encourages the formation of strong friendships; however, every effort is made to keep the relationships between boys and girls at a friendship level only. Junior Staff may not visit cabins or tents of the opposite sex and will refrain from showing any signs of affection for each other while at camp. Friendly hugs or a pat on the back are acceptable.
14. Junior Staff must inform staff if they are experiencing a problem with separation, another camper or other issue. If we are not informed about a problem, we cannot stop the problem or assist the camper. It is the camper's responsibility to seek assistance. If a problem arises between a camper and a particular staff member, the camper needs to seek assistance from another staff member or camp administration.
15. We expect all Junior Staff to have FUN at camp but not at the expense of others. No one should be mistreated by another person while at camp.
16. Junior Staff may find that the camp experience offered by the Everglades Youth Conservation Camp is not suited to them. Discussing this with staff is better than complaining about their situation with other campers.
17. Violation of the CODE OF CONDUCT is grounds for automatic dismissal. Refunds are not given when a camper is dismissed for cause.

I have read the above **JUNIOR COUNSELOR'S CODE OF CONDUCT**. I agree to adhere to all of the above to ensure that my camp experience as well as that of other campers in attendance at the Everglades Youth Conservation Camp is a positive one. ***I understand that failure to adhere to these rules may result in my dismissal from the program.***

\_\_\_\_\_  
Junior Staff Signature

\_\_\_\_\_  
Date

I understand and certify that my child's participation in the Everglades Youth Conservation Camp and its activities is completely voluntary and I have familiarized myself with the camp's program and activities in which my child will be participating. I recognize that certain hazards and dangers are inherent in the camp's events and programs, and I acknowledge that although the camp has taken safety measures to minimize the risk of injury to camp participants, the camp cannot ensure or guarantee that the participants, equipment, premises and/or activities will be free of hazards, accidents and/or injuries. I further recognize and have instructed my child in the importance of knowing and abiding by the camp's **CODE OF CONDUCT** for the safety of all camp participants.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



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**EYCC 5**

## 2014 Everglades Youth Conservation Camp ASSUMPTION OF RISK & PHOTO RELEASE



### Assumption of Risk

#### PLEASE PRINT

Name \_\_\_\_\_ Sex \_\_\_\_\_  
Address \_\_\_\_\_ Age \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Office Phone \_\_\_\_\_ Cell \_\_\_\_\_

I certify that my child is in good health and capable of full participation in the activities of the Everglades Youth Conservation Camp. I am aware that during wilderness trips and/or instruction courses that my child is participating in under the arrangements of the Florida Youth Conservation Centers Network, certain dangers may occur, including but not limited to physical exertion and contact with water, plants, insects and animal life associated with out-of-doors activities, and travel by automobile or conveyance including canoes and bicycles and any type of labor or practices associated with camper or volunteer programming.

In consideration of, and as part payment for my participation in such trips or other services and activities arranged for me by the Everglades Youth Conservation Camp, I will and do hereby assume all of the above mentioned risks, and will hold the Everglades Youth Conservation Camp, Florida Youth Conservation Centers Network or Florida Fish and Wildlife Conservation Commission, the State of Florida and its employees, agents, officers, teachers and volunteers harmless from any and all liability, actions, causes of actions, debts, claims, demands of every kind and nature whatsoever which may arise from or in my child's connection with his/her participation in the activities.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Program Name \_\_\_\_\_

### Photo Release Form for Minors

Florida Youth Conservation Centers Network/Florida Fish and Wildlife Conservation Commission wishes to use photographs, videos or voice recordings of minor children. I am the parent or legal guardian of the minor child named below.

I, the undersigned, consent and agree that Florida Fish and Wildlife Conservation Commission, including its employees, agents and representatives, through the Florida Youth Conservation Centers Network may photograph my minor child with a television camera, video camera or digital camera.

☐ **I hereby consent** to the use, publication or display by or on behalf of Florida Youth Conservation Centers Network, any photographs and any reproduction thereof or any video or voice recordings in which my minor child may be portrayed or identified. It is understood that Florida Fish and Wildlife Conservation Commission may use, publish and display such photos, photo reproductions and video or voice recordings thereof, in whole or in part, for any promotional or commercial purpose (e.g., website, slide shows, brochures, newspapers/magazine articles or other news releases). I waive all claims for any compensation for such use and waive any and all claims for damages of any kind arising directly or indirectly out of this activity.

☐ **I do not consent** to my child being interviewed, photographed or filmed by news media representatives by Florida Fish and Wildlife Conservation Commission staff or volunteers.

Name of Minor Child: \_\_\_\_\_ Cabin#: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Phone \_\_\_\_\_

Signature of Parent/Guardian of Minor Child \_\_\_\_\_

Date \_\_\_\_\_