Florida's Project 10 Kids
Consent, Waiver, Assumption of Risk and Release of Liability

I, _____, understand that participation in the "Project 10 Kids" at Monticello Healthy Fitness Club ("Event") presents certain risks and hazards to my child including, but not limited to, falls, slips, muscle strains, sprains, bruises, broken limbs, dehydration, serious medical problems, hazards along the route, vehicular traffic, and other ordinary risks associated with strenuous physical activity. I acknowledge that I understand that I should consult with my child's physician prior to engaging in any physical activity. My child does not have a past or present medical condition that may be affected by participating in this Event or that I have obtained clearance for my child from a physician before participating in this Event. I understand the seriousness of the risks involved in participating in this program, my child's personal responsibilities for adhering to rules and regulation, and I voluntarily accept and assume all risks involved with this Event on behalf of my child, including any injury or accident which may occur to me or my property.

In consideration of value received by the right to participate in "Project 10 Kids", I, for my child, myself, my attorneys, heirs, executors, administrators, successors and assigns, do hereby waive, release and forever discharge the State of Florida, Department of Health, and its employees, agents, volunteers and/or Monticello Healthy Fitness Club, the contracted party assisting with this Event (hereinafter the "Released Parties") from all manners of action, causes of action, suits, debts, damages, claims, expenses, and liability of any type or kind whatsoever arising from or in connection with this Event, including acts of negligence by the Released Parties. Further, I agree to indemnify and hold harmless the Released Parties from and against all liability, claims, suits, demands, damages, judgments, costs, and expenses, including reasonable attorney's fees, to which any of the Released Parties may be subject by reason of any claim arising from or in connection with this Event.

I also acknowledge and give my consent to release the use of any images of me obtained during this Event to be used in any publication or news release promoting or reporting on this Event.

I have read this Consent, Waiver, Assumption of Risk and Release of Liability, fully understand its terms, understand that I give up substantial rights by signing it, and sign it freely and voluntarily without any inducement.

_____	_____	_____
Participant's Signature	Participant's Printed Name	Date Signed

Parent or guardian consent for children under 18 years of age:
I agree to allow my child, _____, to participate in this Event. I have read the above-stated consent, waiver, assumption of risk, and release of liability and agree to its terms. I represent that my child is in good physical condition and able to participate.

_____	_____	_____
Parent/Guardian's Signature	Parent/Guardian's Printed Name	Date Signed

Child Health History Form

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Work)		Sex M ☐ F ☐

Has the child had any history of, or conditions related to, any of the following:

☐ Anemia	☐ Cancer	☐ Epilepsy	☐ HIV +/AIDS	☐ Mononucleosis	☐ Thyroid
☐ Arthritis	☐ Cerebral Palsy	☐ Fainting	☐ Immunizations	☐ Mumps	☐ Tobacco/Drug Use
☐ Asthma	☐ Chicken Pox	☐ Growth Problems	☐ Kidney	☐ Pregnancy (teens)	☐ Tuberculosis
☐ Bladder	☐ Chronic Sinusitis	☐ Hearing	☐ Latex allergy	☐ Rheumatic fever	☐ Venereal Disease
☐ Bleeding disorders	☐ Diabetes	☐ Heart	☐ Liver	☐ Seizures	☐ Other_____
☐ Bones/Joints	☐ Ear Aches	☐ Hepatitis	☐ Measles	☐ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____

Child's History

		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	1. ☐	☐
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	2. ☐	☐
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	3. ☐	☐
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	5. ☐	☐
6.	Has the child ever been hospitalized?	6. ☐	☐
7.	Does the child have a history of any other illnesses? If yes, please list: _____	7. ☐	☐
8.	Has the child ever received a general anesthetic?	8. ☐	☐
9.	Does the child have any inherited problems?	9. ☐	☐
10.	Does the child have any speech difficulties?	10. ☐	☐
11.	Has the child ever had a blood transfusion?	11. ☐	☐
12.	Is the child physically, mentally, or emotionally impaired?	12. ☐	☐
13.	Does the child experience excessive bleeding when cut?	13. ☐	☐
14.	Is the child currently being treated for any illnesses?	14. ☐	☐
15.	Has your child ever seen a dentist?	15. ☐	☐
16.	Has the child had any problem with dental treatment in the past?	16. ☐	☐
17.	Has the child ever had dental radiographs (x-rays) exposed?	17. ☐	☐
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	18. ☐	☐
19.	Has the child had any problems with the eruption or shedding of teeth?	19. ☐	☐
20.	Has the child had any orthodontic treatment?	20. ☐	☐
21.	What type of water does your child drink? ☐ City water ☐ Well water ☐ Bottled water ☐ Filtered water		
22.	Does the child take fluoride supplements?	22. ☐	☐
23.	Is fluoride toothpaste used?	23. ☐	☐
24.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	24. ☐	☐
25.	Does the child suck his/her thumb, fingers or pacifier?	25. ☐	☐
26.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27.	Does child participate in active recreational activities?	27. ☐	☐

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

Comments _____

For Office Use Only: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia Reviewed by _____

Date _____