



**THE EIGHTH ANNUAL GREAT LAKE ERIE BOAT FLOAT  
LIABILITY WAIVER AND RECOGNITION OF RISK AGREEMENT**

- I. IN CONSIDERATION of being given the opportunity to participate in the Eighth Annual Great Lake Erie Boat Float (hereinafter referred to as the Boat Float) my child/ward and I, hereby release, indemnify, save, hold harmless, waive, discharge, and covenant not to sue The Cleveland Museum of Natural History, the Board of Park Commissioners of the Cleveland Metropolitan Park District (Cleveland Metroparks), the City of Cleveland, the State of Ohio, the Ohio Department of Natural Resources, their employees, officers, or agents (hereinafter collectively referred to as the "Releasees"), from any liability, claims, demands, actions, and causes of action whatsoever arising out of or related to any loss, damage, cost, or injury, including death, whether caused by the negligence of Releasees or otherwise, including negligent rescue operations.
- II. I am fully aware of the risks involved and hazards connected with the recreational activities at Cleveland Metroparks Lakefront Reservation-Edgewater Park associated with the Boat Float including those related to paddling in Lake Erie but not limited to that activity. I hereby elect to voluntarily participate in said activity with full knowledge that said activity may cause bodily injury, death, or property damage. I acknowledge that I am in good health and in proper physical condition to participate in the Boat Float. I agree to take all necessary safety precautions while participating in the Boat Float, including, but not limited to, wearing a life jacket at all times. I voluntarily assume full responsibility for any risks or loss, property damage or personal injury, including death.
- III. It is my express intent that this Liability Waiver and Recognition of Risk Agreement ("Agreement") shall bind the members of my family, my representatives, my next of kin, and my spouse.
- IV. My participation and my family's participation in the Boat Float represent our consent to having our pictures, voice, actions, appearance, and likeness recorded and taken and used for promotional materials in perpetuity. I understand I will not receive compensation for such use in future promotions.
- V. I intend for this Agreement to be as broad and inclusive as permitted by the laws of the State of Ohio. If any portion of this Agreement is held invalid, I agree that the balance of this Agreement shall continue in full force.
- VI. In signing this Agreement, I acknowledge and represent that I have read the foregoing Agreement, understand it, and voluntarily sign it as my own free act and deed. I am at least eighteen years of age and fully competent. Further, as the legal guardian or parent of a child under the age of 18 years and a participant in the Boat Float, I also waive and release and all rights as outlined in the Agreement related to my child or ward.

***(This form must be completed, signed and returned before participating in the Boat Float)***

Participant's Name \_\_\_\_\_ Birth Date (if under 18) \_\_\_\_\_

Parent/ Guardian's Name (if under 18) \_\_\_\_\_

Parent/ Guardian's Signature (if under 18) \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ (Home) \_\_\_\_\_ (Other) \_\_\_\_\_

Participant's Signature \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL TREATMENT RELEASE FORM MUST ALSO BE COMPLETED**

## MEDICAL TREATMENT RELEASE

To Whom It May Concern:

In the event of injury, I authorize (on behalf of myself and my child/ward) a representative of The Cleveland Museum of Natural History, Cleveland Metroparks, or the City of Cleveland to obtain first aid and/or medical treatment at the nearest and most adequate facility of their choice.

Participant's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Sex \_\_\_\_\_

Parent/ Guardian's Name  
\_\_\_\_\_

Home Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Name of Employer \_\_\_\_\_

Health Insurance Carrier \_\_\_\_\_

Name on Health Insurance \_\_\_\_\_

Policy or Group Number \_\_\_\_\_

Allergies (Bee Stings, Aspirin, Hay Fever, Asthma, Food, Other) \_\_\_\_\_

If not available in an emergency, notify:

Name \_\_\_\_\_

Home Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

This release is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances for myself, or in my absence, for the minor child/ward listed.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(by adult participant or guardian of minor child/ward)

Address \_\_\_\_\_ City/Zip \_\_\_\_\_

Phone \_\_\_\_\_