

# BROOKFIELD ZOO MEDICAL WAIVER FORM

## Medical Waiver Form Explanation

The following is a medical waiver form for your child.

In any medical emergency (bee sting, scrape, sprain, cut, etc.), Brookfield Zoo's Police Department is contacted. An emergency medical technician performs first aid on your child and immediately places a call to you. This call is to notify you of the incident and to inform you of any additional treatment options, which you may accept or refuse. Until you are reached, your child remains in the First Aid Office and cannot be released back into the zoo. If you cannot be reached within a reasonable amount of time, a call is placed to Loyola Medical Center. Medical staff at Loyola Medical Center will decide if your child needs to be transported by ambulance to their facility. Payment of the ambulance and any treatment at Loyola Medical Center are your responsibility. With this medical waiver in place, if you are unable to be reached, Brookfield Zoo program staff can make the decision to accept or refuse medical treatment on behalf of your child. Please bring the completed form at the time of the program.

## AUTHORIZATION FOR MEDICAL TREATMENT OF A MINOR

(Please complete a separate form for each child.)

I/we, being the parent(s)/legal guardian(s) of \_\_\_\_\_, a  
(child's name – birth date/age)

minor, do hereby appoint Brookfield Zoo staff to act on my/our behalf, in the event that I/we cannot be contacted, to authorize or refuse necessary emergency treatment while participating in programs at Brookfield Zoo \_\_\_\_\_.  
(dates)

I understand that I will be responsible for the payment of all costs incurred incident to such treatment. I will not hold Brookfield Zoo in any way responsible for accidents and/or injury to the child that are wholly or in part resulting from facilities, acts, or omissions not directly managed by the Chicago Zoological Society at Brookfield Zoo.

**Mother/father/legal guardian: Please fill out this form as completely as possible, circling the most likely way to reach you during the program.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name, relationship to child

\_\_\_\_\_  
Name, relationship to child

\_\_\_\_\_  
Home address

\_\_\_\_\_  
Home address

\_\_\_\_\_  
City/State/Zip Code

\_\_\_\_\_  
City/State/Zip Code

\_\_\_\_\_  
Home phone number

\_\_\_\_\_  
Home phone number

\_\_\_\_\_  
Cellular phone number

\_\_\_\_\_  
Cellular phone number

\_\_\_\_\_  
Other emergency contacts and phone numbers:

Please check yes or no if your child has been immunized for:

Yes

No

Tetanus booster

Mumps, measles, rubella

Polio

Haemophilus influenzae type B

Pneumococcal

Hepatitis B

Hepatitis A

Chicken Pox

Meningococcal meningitis

Diphtheria, tetanus, pertussis


When was the date of your child's last tetanus shot? \_\_\_\_\_

To help us provide the best possible experience, please specify allergies, medical problems, medications prescribed or over the counter medication your child is taking physical needs, behavioral needs, or learning disabilities concerning your child.

---

---

---

Describe any activities from which the participant should be exempted for health reason.

---

---

---

Please list the name and phone number of your camper's physician or health care facility.

---

---