

**ARK ENCOUNTER OVERNIGHT STAY**  
Permission, Liability Release and Medical Authorization Form

Ark Encounter Overnight Stay

DATE \_\_\_\_\_  
CHILD'S NAME \_\_\_\_\_ AGE \_\_\_\_\_  
PARENT/GUARDIAN NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
PHONE (\_\_\_\_) \_\_\_\_\_  
ALTERNATE EMERGENCY PHONE (\_\_\_\_) \_\_\_\_\_

**Consent to attend**

I hereby authorize \_\_\_\_\_ (my child or ward) to participate in an overnight stay and in all activities involved with the stay at the Ark Encounter on \_\_\_\_\_, 20\_\_\_\_. I hereby release, and agree to indemnify and hold harmless, Ark Encounter, LLC, Crosswater Canyon, Inc., and Answers in Genesis, Inc., and all their respective directors, officers, managers, owners, employees, volunteers, agents and representatives (collectively, the "Released Parties") from and against any and all liabilities, loss, or damage to persons or property which may occur in connection with the overnight stay program at the Ark Encounter (the "program"), to the fullest extent permitted by law. I agree to assume all risks associated with my child's participation in the program.

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

**Permission to render emergency medical care**

I \_\_\_\_\_, the \_\_\_\_\_ (father, mother, guardian) of \_\_\_\_\_ (child's name), the minor participating in the overnight stay, hereby authorize public safety personnel of Answers in Genesis, Crosswater Canyon, and Ark Encounter, and their other assigned safety personnel, employees, volunteers, agents, and representatives to render emergency medical care to my child within their scope of training, and to act on my behalf to consent to any medical, hospital or emergency care or treatment deemed to be necessary or advisable for the child upon the advice of any licensed physicians, dentists, nurses, or emergency medical personnel. I also give consent for my child to be transported to an emergency medical care center if the need arises. I agree to be responsible for all necessary charges incurred by any transportation, hospitalization or treatment rendered pursuant to this authorization. I agree to indemnify and hold harmless the Released Parties from any and all liability in connection with such medical treatment.

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

**Medical Information**

Family Physician's name \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_

**CHILD'S MEDICAL HISTORY**

Is child in good health? \_\_\_\_\_ List Allergies: \_\_\_\_\_

\_\_\_\_\_ Date of last tetanus shot: \_\_\_\_\_

List any physical impairments (such as Heart, Epilepsy, Diabetes, etc.):

\_\_\_\_\_

Specify any medication that must be administered:

\_\_\_\_\_

Other special instructions \_\_\_\_\_

\_\_\_\_\_

Health Insurance company name: \_\_\_\_\_

Policy Number \_\_\_\_\_ Telephone \_\_\_\_\_

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