

# Minor Liability Release Form

*For Lenspiration Photography Workshop attendees under the age of 18*

## Attendee Information

First/Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent/Legal Guardian name(s): \_\_\_\_\_

## Release Details

I, the Attendee's Parent/Legal Guardian, understand the nature of the activities associated with the Lenspiration Photography Workshop(s) held on \_\_\_\_\_, and believe the Attendee to be qualified, in good health, and in proper physical condition to participate in these activities. I fully understand that this event may take place at multiple locations, span multiple days, involve an element of risk, and that the Attendee will be under the supervision of the designated staff. I assume all risks and hazards incidental to such participation and do hereby release, absolve, indemnify, and agree to hold harmless Workshop staff, representatives, drivers, and volunteers from any and all liability that may arise out of participation in this event. I also give consent for emergency medical treatment if necessary, though I do request that, if possible, I be contacted prior to treatment. As Parent/Legal Guardian, I remain fully responsible for any legal responsibility which may result from any personal actions taken by the named Attendee.

I also hereby give permission for photos/videos to be taken of the Attendee, and understand that this media may be used by Lenspiration for promotional, commercial, and/or educational purposes.

Since it is strongly encouraged that a Parent/Legal Guardian attend with an Attendee under the age of 18, I choose one of the following:

☐ A Parent/Legal Guardian will attend

☐ I authorize \_\_\_\_\_ to fill the role of guardian on-location during the Workshop

Parent/Legal Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Alt. Emergency Contact: \_\_\_\_\_

## Attendee Medical Information

Personal physician or health-care provider: \_\_\_\_\_

Present medications: \_\_\_\_\_ ☐ None

Special dietary restrictions: \_\_\_\_\_ ☐ None

Food allergies/medication allergies: \_\_\_\_\_ ☐ None

Further Medical Information: \_\_\_\_\_ ☐ None

➤ *Please send completed form to [info@lenspiration.com](mailto:info@lenspiration.com)*

