

Kid's Saltwater Fishing Workshop

AGES 8-17

Pick your choice date of workshop _____

Time of Workshop 9:00 am -12:00 pm

Complete one registration form per participant

Program Meets at the Visitor's Center/ Sea Wall

Workshop Fee: \$20.00 per participant

Make \$20.00 check payable to Friends of Washington Oaks Gardens State Park

Kid's Name: _____ Birth Date: _____

Parent's Name: _____

Address: _____ Zip Code _____

Home Phone # _____ Cell Phone # _____

How did you hear about the workshop? _____

Date Paid _____ Cash/Check#/Money Order _____

Please list any special needs _____

Reservations are on a first come first serve basis. Workshop reservation is confirmed upon payment. NO REFUNDS

Photo Release for Minors

I being Parent/Guardian of _____, hereby consent that the videotapes, photographs and/or motion picture film for which he/she posed, and/or audio recordings made of his/her voice may be used by the Florida Department of Environmental Protection, its assigns or successors, in whatever way they desire, including television without compensation. Furthermore, I hereby consent that such photographs, films, negatives, and recordings and the plates and/or tapes or other medium from which they are made shall be their property, and they shall have the right to sell, duplicate, reproduce and make other uses of such photographs, films, recordings, plates, and tapes as they may desire free and clear of any claim whatsoever on my part or my child's part, or by anyone who may claim by or through my child in perpetuity.

IN WITNESS WHEREOF I have hereunto set my hand, in the State of Florida, this _____ day of _____, 2_____

Signature of parent or guardian _____

RETURN THIS FORM WITH PAYMENT TO:

Friends of Washington Oaks Gardens State Park

6400 N. Oceanshore Blvd.

Palm Coast, FL 32137

(386) 446-6783

e-mail:Melissa.Kafel@dep.state.fl.us

PARENTS PLEASE COMPLETE THE HEALTH FORM ATTACHED

Pick Up Form/Health Information

Your child will be participating in the Kid's Saltwater Fishing Workshop at Washington Oaks Gardens State Park. Please complete the information below and return with the registration. Also, it is important that we have a list of persons that are allowed to pick up your child from the park, along with their telephone number(s). Please inform the person picking up your child that they must present photo identification at time of pick up.

HEALTH INFORMATION

Child's Name _____ Date of birth _____ Age _____

Allergic reactions:

Bee Stings _____ Penicillin _____ Fire Ants _____

Wasp _____ Poison ivy _____ Sumac _____

Other _____

Details of above or additional information: _____

Does the child have any visual, hearing or learning difficulties? _____

Frequent colds _____ Asthma _____ Sinusitis _____

Heart trouble _____ Bronchitis _____ Stomach upsets _____

Fainting _____ Diabetes _____ Epilepsy _____

Ear infections _____ Fainting _____

PICK UP APPROVAL

The following person(s) have my permission to pick up my child _____ from Washington Oaks Gardens State Park:

Name _____ Relationship _____ Phone# _____

Name _____ Relationship _____ Phone# _____

Parent/Guardian Signature _____ Date _____