



Registration Information, Medical and Publicity Release Form

- This event is open to bands and choirs from all age groups.
• All orders postmarked after the deadline will be charged an additional \$2.00 per ticket...
• Please plan an additional 30 - 60 min for entry and set up before your scheduled performance time.
• DO NOT MAIL YOUR MEDICAL RELEASE FORMS. Please bring them with you on the day of your performance.

SIX FLAGS GREAT ADVENTURE: Please copy this form for EACH participant.
MEDICAL AND PUBLICITY RELEASE FORM
(Please print clearly)

Participants Name: _____

School/Group Name: _____

1. Medical Release

- a. I understand that by taking part in this or any performance, there is a possibility of injury or sickness to me/my minor child; therefore, I give permission for me/my minor child to participate in Performance in the Park at Six Flags Great Adventure in Jackson, NJ, and do hereby grant permission to Six Flags Great Adventure medical staff and hospital staff members to administer immediate treatment to me/my minor child should I/she/he be injured.
b. I also agree to hold harmless Six Flags Great Adventure, Six Flags Ent. its officers and agents for any injury or loss of life, incurred as a result of me/my minor child's participation in Performance in the Park.

2. Publicity Release

- a. I except where prohibited by law, I hereby irrevocably grant to Six Flags Great Adventure and its parent companies, successors and assigns, the absolute right and permission to use my name, photograph, video, hometown and state for promotional purposes in any manner or media whether now existing or hereafter created (including, without limitation, in publications and online), worldwide, in perpetuity, without notice to me and without limitation, condition, consideration, consent or compensation. I shall have no right of approval, no claim to any compensation, and no claim arising out of the use, alteration, distortion or illusionary effect or use in any composite form of any of the foregoing attributes of my identity.

Participants/Parents Name: _____

Print: _____ Sign: _____

Address: _____

Home Phone: _____ Business Phone: _____

Insurance Co.: _____

Any Medication Allergies: _____

Family Doctor: _____ Doctors Phone: _____