



1807 South Metro Parkway  
Dayton, Ohio 45459  
937-428-9836

## Consent to Treat/Photo Release/Email Permission Form

### REGISTRATION INFORMATION – Please Print

Full Legal Name \_\_\_\_\_  
First Middle Last

Nickname \_\_\_\_\_

Phone (Cell) (\_\_\_\_\_) \_\_\_\_\_ (Home) (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ DOB: (day/month/year) \_\_\_\_\_

City, State \_\_\_\_\_

Zip/Postal Code \_\_\_\_\_

Email: \_\_\_\_\_

Do you want to be notified of Dive Activities? YES \_\_\_\_\_ NO \_\_\_\_\_

If YES. In the future, we may send you monthly emails with course specials, travel, or diving opportunities.  
You'll be able to unsubscribe at any time, and we never share your information.

### Consent to Treat:

In the event of injury or illness, I authorize (on behalf of myself or my child/ward) Aquatic Realm Scuba Center, LLC to obtain first aid and/or medical treatment at the nearest and most adequate facility of Aquatic Realm Scuba Center, LLC choice. This release is completed and signed of my own free will and with the sole purpose of authorizing medical treatment under emergency circumstances for myself, or in my absence, for the minor child/ward listed.

### Photo Release:

I authorize Aquatic Realm Scuba Center to publish, in print, electronic, or video format, the likeness or image of myself or my child/ward, without limitation.

PARTICIPANT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(day/month/year)

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(if minor) (day/month/year)

### In case of emergency contact: (Please use someone that is not in a class with your)

NAME: RELATIONSHIP: CELL PHONE:

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