Please return this form by *April 7, 2018* to:

Kelly Wald
120 W Santee Road Unit 6, Lincoln ND 58504
kellyjwald@gmail.com

Participant Confirmation Form

(Please type or print legibly)

Mr. ☐ / Ms. ☐ _____
(Last name) (First name)

Birth date: ____/____/____ Social Security # (last 4 digits only): _____

Address: _____

City: _____ State: _____ Zip code: _____

Home Telephone Number: (____) _____ Email: _____

T-Shirt Size: ☐ S / ☐ M / ☐ L / ☐ XL / ☐ XXL / ☐ XXXL

Preferred name for nametag: _____

Newspaper Name: _____ City: _____

Travel Information

Participant will arrive at the HOBY Event by:

☐ CAR ☐ BUS ☐ TRAIN ☐ PLANE

If traveling by car, participant will be driven by (name of driver): _____

Telephone number: (____) _____ OR _____ Participant will be driving him/herself to the event.

If traveling by bus, train, or plane – Name of Carrier: _____

Bus/Train/Flight Number: _____ Arrival Date: _____ Arrival Time: _____ AM / PM

How will student be transported between bus/airport/train station and event facility? _____

_____

If departure plans are different, please explain: _____

_____

If departing by bus, train, or plane – Name of Carrier: _____

Bus/Train/Flight Number: _____ Departure Date: _____ Departure Time: _____ AM / PM

I UNDERSTAND THAT ALL TRANSPORTATION TO AND FROM THE EVENT FACILITY IS MY RESPONSIBILITY. THIS INCLUDES RESPONSIBILITY FOR MY SON OR DAUGHTER DURING ANY CONNECTION FLIGHTS, BUS TRANSFERS, OR IN BETWEEN MODES OF TRANSPORTATION.

Signature of Parent/Legal Guardian: _____ **Date:** _____

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Medical History Records Form

(Please type or print legibly)

Dear Participant:
For our records, and for your protection, please have your parent or legal guardian complete this form in its entirety. Please provide ALL requested information and obtain the signature of your parent or legal guardian.

PARTICIPANT PERSONAL INFORMATION

Last name First name Middle initial

Gender Date of birth Place of birth

(Area code) Telephone number High school/Institution participant represents

Participant's permanent street address

City State Zip code

EMERGENCY CONTACT INFORMATION

Last name First name Relationship to participant

(Area code) Primary telephone number (Area code) Secondary telephone number

Name of family physician (area code) Physician telephone number

PARTICIPANT PERSONAL MEDICAL HISTORY

Please check the following diseases the participant has had in the past:

- ☐ Chicken Pox
- ☐ Diphtheria
- ☐ German Measles (Rubella)
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Polio
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Tonsilitis

Check the following conditions the participant has had or are subject to now:

- ☐ Anxiety
- ☐ Asthma
- ☐ ADD/ADHD
- ☐ Bleeding tendencies
- ☐ Emphysema/ Bronchitis
- ☐ Congestive Heart Failure
- ☐ Depression
- ☐ Diabetes
- ☐ Ear Infection
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Hay Fever
- ☐ Headache
- ☐ Heart Disease
- ☐ Hearing Loss
- ☐ Migraine
- ☐ Nose Bleed
- ☐ Seizures
- ☐ Difficulty Sleeping
- ☐ Upset stomache
- ☐ Vision Loss
- ☐ Other_____
- ☐ Other_____

What treatments or medications (if any) does the participant require for any of the above conditions?

Has the participant ever been hospitalized or had serious illnesses? If so, please explain in detail.

If there are any limitations on the amount of physical exercise the participant can engage in, please describe and explain (use additional sheet of paper if necessary):

Please list all allergies (insect stings, plants, foods, etc) and any dietary needs or restrictions.

(Please continue to Page 2)

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Medical History Records Form (page 2)

MEDICATION

Please list any medications the participant has allergic reactions to (penicillin, sulfa drugs, tetnus antioxin, etc.) and what the reaction is:

_____

_____

Please list any prescription medications the participant is taking, including: (1) name and type of medication; (2) condition for which medication is being prescribed; and (3) dosage information. Please also list any non-prescription medication the participant takes regularly. **Please read HOBY's Policy for Use of Medication During a HOBY Event and have the participant bring a doctor's note to the event.** By signing this form, you attest that the use of the medication will not impair the participant's ability to care for his/her own safety or the safety of others; increase the risk of harm to others; or cause dizziness and/or fatigue.

_____

_____

Please mark the below over-the-counter medications that you approve to be administered to your child by HOBY:

- ☐ ibuprofen (such as Advil, Motrin)
- ☐ acetaminophen (such as Tylenol)
- ☐ diphenhydramine (such as Benadryl)
- ☐ naproxen (such as Aleve)
- ☐ throat lozenges
- ☐ Pepto Bismol
- ☐ loperamide (such as Imodium)
- ☐ decongestant (please specify if a specific decongestant is necessary: _____)
- ☐ antibiotic ointment (such as Neosporin, Polysporin, Bacitracin)
- ☐ eye drops (such as artificial tears or saline)
- ☐ Gas-X
- ☐ other (please specify: _____)

IMMUNIZATIONS

Please list the type of illness the participant has received immunizations for:

Type of Illness:	Approximate Date(s) of Immunization:
☐ Hepatitis B	
☐ DPT (Diptheria, Pertussis, Tetanus)	
☐ Tetanus booster (Please indicate date of last booster)	
☐ Hib (Haemophilus influenzae type B)	
☐ Polio	
☐ MMR (Measels, Mumps, Rubella)	
☐ Chicken pox (Varicella)	
☐ Influenza (Flu shot)	
☐ Pneumonia (Pneumococcal)	
☐ Meningitis (Meningococcal)	
☐ Smallpox	
☐ Typhoid	

I verify that all information provided in this Medical History Records Form is complete and accurate.
I hereby give my permission to HOBY to store the above prescription medication listed to my child. I understand and have discussed with my child that it is the responsibility of my child to take the medication as directed by his or her physician while at a HOBY event. I also give permission for HOBY to administer over-the-counter medications that I have approved above that may be necessary to treat minor conditions. I understand that if HOBY deems necessary, they will take my child to a hospital or other medical facility for more intensive treatment. I understand that all HOBY staff, volunteers and HOBY, as an organization, are not liable for any adverse affects that may occur due to this medication and they are not liable in the possibility that a child misses a prescribed dose or in the event the medication is administered incorrectly. I also state that all the above information is complete and accurate and any misapplication of medication due to inaccurate, incomplete, or unreadable information is not the responsibility of HOBY. I also understand that the HOBY staff, volunteers and HOBY, as an organization, are not responsible if my child fails to present themselves at the announced places/times to take the above specified medication.

_____ _____

Signature of Participant **Signature of Parent/Legal Guardian**

_____ _____

Date **Date**

Policy for Use of Medication During a HOBY Event

If a minor or adult participant is required to take medication during a HOBY event, including the HOBY Leadership Seminar, he/she must comply with the following guidelines:

1. HOBY volunteers will not dispense prescription medication for participants during the event.

2. Any participant bringing prescription medication to the event must submit a doctor's note or completed Physician Medication Verification Form to HOBY, preferably in advance or at the event check-in, detailing the following:

    a. The name and type of medication.

    b. The condition for which the medication is being prescribed.

    c. Dosage information.

    d. Attestation that use of the medication will not impair the participant's ability to care for his/her own safety or the safety of others; increase the risk of harm to others; or cause dizziness and/or fatigue.

    This information is necessary to provide medical personnel in the case of emergency and the participant is unable to communicate the information. All prescription medication must be submitted to HOBY in its original container as labeled by the pharmacy. HOBY will store required medications in a locked facility. The medications a participant may be allowed to keep in his/her possession is any asthma medications (inhalers, oral steroids, etc.), birth control pills, acne medication, any topical medications, allergy medications, medications for treatment of diabetes (insulin, etc.) and EpiPens, as well as any other prescription medication required by the doctor to be in their possession at all times. But there will need to be a doctor's note completed and on file for all medication brought to the event, whether stored or not.

    If a participant fails to advise HOBY that he/she is taking prescription medication, is not taking the medication as prescribed, and/or has stopped taking prescription medication, HOBY reserves the right to send the participant home at the participant's guardian or parent's expense.

3. If the participant has a medical condition that requires any assistance, the assistance must be provided or contracted directly by the participant or his/her parent/guardian. Under no circumstances will a HOBY volunteer help with dispensing medication. If help is needed on an emergency basis, emergency personnel will be contacted.

4. Proper administration and dosage of medication shall be the sole responsibility of the participant. HOBY will have no responsibility in seeing that the participant takes the medication as prescribed by the doctor.

5. Participants should only bring as much medication as will reasonably be needed during the event.

6. Participants are prohibited from sharing their personal medication with another participant. Conversely, participants are prohibited from accepting medication from anyone, other than HOBY medical staff.

7. Any participant bringing illegal drugs, narcotics, misused prescription drugs and/or mood altering substances or alcoholic beverages to a HOBY event, using them on HOBY premises or dispensing or selling them on HOBY premises will be subject to disciplinary action, including automatic expulsion from the event. The discharged participant will be responsible for any charges/fees incurred as a result of leaving the event early (i.e. change in airfare, taxi, etc.). HOBY has a very strict/no-tolerance policy when it comes to drugs.

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Medication Verification Form for Physicians

(Please type or print legibly)

This form is to be completed by the participant's prescribing physician. If the participant has more than one prescribing physician, each physician will need to complete a form. Please type or print legibly.

1. Name of Participant/Patient: _____
2. Prescribing Physician Name: _____
3. Prescribing Physician Medical License Number and State where licensed: _____
4. Please complete the chart below for the medications which you have prescribed to the participant.

Name of Medication	Type of Medication	Condition for Treatment	Dosage	Frequency

5. Please affix physician's business card or voided prescription in the space below.

As the prescribing physician, I attest that the use of the medications prescribed by me, and taken as directed as listed above, should not impair the participant's ability to care for his/her own safety or the safety of others; increase the risk of harm to others; or cause dizziness and/or fatigue.

Signature of Prescribing Physician: _____ **Date:** _____

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Health Insurance Form

(Please type or print legibly)

6. Name of Participant: _____

7. Health insurance plan name: _____

8. Health insurance plan number: _____

4. Health insurance group number: _____

5. Check here ____ if participant is not covered by a health insurance plan.

6. Name of parent or legal guardian: _____
Last First

7. Emergency contact telephone number: _____
(Area Code)

Signature of Parent/Legal Guardian: _____ Date: _____

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Consent & Acknowledgement of Risk Form

(Please type or print legibly)

Participant's Name: _____

Event/Activities: _____

Dates: _____ Location: _____

IN CONSIDERATION of the right to attend and participate in the Activities described above, the Participant (and, if the Participant is a minor, his or her parent or legal guardian) hereby:

1) Agrees to abide by all rules and regulations established by Hugh O'Brian Youth Leadership (HOBY);

2) Authorizes HOBY or any of its agents to provide, obtain, or authorize any reasonable incidental and/or emergency medical treatment for the Participant, in the event of the Participant's illness, injury, or incapacity, and hereby accepts the responsibility to pay for such treatment;

3) Grants to HOBY for any purpose connected with promoting the purposes and goals of HOBY, but not for commercial exploitation, the right to use the Participant's name, voice, and likeness in any writings, photographs, films, and recordings of the Participant while he or she is participating in the Activities, and any biographical information submitted by the Participant to HOBY, and to use, reproduce, publish, and distribute the same;

4) Acknowledges that there is an element of risk involved in any activity involving travel outside of one's own home or community; certifies that the Participant is physically, mentally, and emotionally capable of attending and participating in the Activities; assumes all risk of and financial responsibility for any loss or injury to the Participant or others that may occur as a result of the Participant's negligence or misconduct; and indemnifies and holds HOBY harmless from and against any and all costs, claims, demands, charges, liabilities, obligations, judgments, executions, costs of the suit and actual atorneys' fees incurred or suffered by HOBY as a result of, or arising out of, the Participant's negilgence or misconduct;

5) Agrees to immediately advise in writing the person in charge of the HOBY event and/or HOBY International of any injury, illness, or loss that occurs to the Participant during the event;

6) This Consent and Ackowledgment of Risk shall not be amended, supplemented, or abrogated without the written consent of HOBY's International Office in Los Angeles, California;

7) The Participant (and, if the participant is a minor, his or her parent or legal guardian) has read this Consent and Acknowledgment of Risk, and understands its contents.

Signature of Participant: _____ **Date:** _____

IF PARTICIPANT IS A MINOR, SIGNATURE OF HIS OR HER PARENT/LEGAL GUARDIAN IS REQUIRED:

Name of Parent/Legal Guardian: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Signature of Parent/Legal Guardian: _____ **Date:** _____

TO BE NOTARIZED

STATE OF _____ COUNTY OF _____

On _____ before me the undersigned, a Notary Public in and for said _____ State, personally appeared _____, personally known to me, or proved to me on the basis of satisfactory evidence, to be the person whose name is subscribed to the within instrument and acknowledged that executed the same.

WITNESS my hand and official seal.

Signature: _____ **Name:** _____

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Notice of Privacy Practices

WE PROVIDE THIS NOTICE TO DESCRIBE HOW MEDICAL INFORMATION ABOUT YOUR CHILD OR DEPENDENT MAY BE USED AND DISCLOSED. PLEASE REVIEW THE BELOW INFORMATION CAREFULLY AND IF YOU AGREE, PLEASE EXECUTE THE ATTACHED AUTHORIZATION.

We understand the importance of privacy and are committed to maintaining the confidentiality of your child or dependent's medical information. We may preserve the medical disclosure information ("medical information") concerning your child or dependent provided by you to HOBY for up to seven years. We use and retain these records to provide or enable health care providers to provide quality medical care to your child or dependent in the event of an emergency. This notice describes how we may use and disclose your child or dependent's medical information. It also describes your rights, the rights of your child or dependent, and our legal obligations with respect to your child or dependent's medical information.

A. How HOBY May Use Or Disclose Your Child Or Dependent's Medical Information

HOBY collects health information about your minor child or dependent and stores it in a file and on a computer. These files are the property of HOBY, but the information belongs to you and your child or dependent. The law permits us to use or disclose your child or dependent's medical information for the following purposes:

1. Treatment. In the event of an emergency, we will provide medical information about your child or dependent to the appropriate health care provider to provide for the medical care of your child or dependent. We may also disclose medical information to members of your family or others who can help your child or dependent if you are not available.

2. Awareness. We may also provide medical information about your child or dependent to HOBY employees and/or volunteers to the extent necessary.

3. Alumni Activities. We may provide medical information about your child or dependent to HOBY employees and/or volunteers in connection with alumni activities or events in which your child or dependent may be a participant.

4. Limited Disclosure. We will limit the use and disclose of medical information about your child or dependent as detailed below.

B. When HOBY May Not Use Or Disclose Medical Information

Except as described in this Notice of Privacy Practices, HOBY will not use or disclose health information which identifies your child or dependent without your written authorization.

C. Your Health Information Rights

1. Request for Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by way of a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request and will notify you of our decision.

2. Copy of Notice. You have a right to a paper copy of this Notice of Privacy Practices.

If you would like to have a more detailed explanation of these rights, or if you would like to exercise one or more of these rights, contact Hugh O'Brian Youth Leadership at (310) 474-4370.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received.

E. Questions or Complaints

Questions or complaints about this Notice of Privacy or how HOBY maintains the medical information of your child or dependent should be directed to Hugh O'Brian Youth Leadership at (310) 474-4370.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of the Notice of Privacy Practices.

Signature of Parent/Legal Guardian: _____ Date: _____

Name of Participant: _____