World Affairs Seminar Delegate Health Form

Please complete ALL requested information. All information is CONFIDENTIAL and will only be shared with nursing staff and staff counselors, as necessary.

Delegate Information

All information in this section is pertaining to the delegate (i.e. the participant of the World Affairs Seminar program).

Full Legal Name *

First | Middle Initial | Last

Preferred Name

First Name | Last Name

Leave blank if same as legal name.

Date of Birth *

Sex *

- Female
- Male
-

Pronouns

- He/him/his
- She/her/hers
- They/them/theirs
- Ze/zir/hir
-

Pronouns are the words you may like others to use for you in place of your proper name. Some examples include "she/her" or "he/him" or gender-neutral pronouns.

Place of Birth

City

State/Region/Province

Country

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Permanent Home Address

Street Address

Address Line 2

City

State/Region/Province

Postal / Zip Code

Country

Primary Telephone Number *

Cell Phone that Delegate will carry during the Seminar

Parent/Guardian Information

All information in this section is pertaining to the delegate's parent(s) and/or guardian(s) (i.e. somebody whom we may contact regarding the participant).

Primary Parent/Guardian Contact Information (REQUIRED)

The World Affairs Seminar will contact the primary parent/guardian first.

Relationship to Delegate *

- Mother
- Father
- Grandparent
- Guardian
-

Primary Parent/Guardian Name *

Title

First

Last

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Primary Parent/Guardian Home Phone

Primary Parent/Guardian Mobile Phone

Primary Parent/Guardian Work Phone

Additional Parent/Guardian Contact Information

In the event that we cannot contact the primary parent/guardian, please provide contact information for an additional parent/guardian.

Additional Parent/Guardian Name

Title *First* *Last*

Relationship to Delegate

- Mother
- Father
- Grandparent
- Guardian
-

Additional Parent/Guardian Home Phone

Additional Parent/Guardian Mobile Phone

Additional Parent/Guardian Work Phone

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Please complete ALL requested information. All information is CONFIDENTIAL and will only be shared with nursing staff and staff counselors, as necessary.

Do you require any special dietary considerations? *

If yes, please describe in detail. If none, please respond "N/A".

Do you have any physical/exercise limitations? *

If yes, please describe in detail. If none, please respond "N/A".

Check any/all conditions that apply to you

☐ Asthma ☐ Convulsions / seizures ☐ Diabetes ☐ Hearing/ Vision Loss ☐ Heart Problems

☐ High Blood Pressure ☐ Migraines ☐ None

Select all that apply.

Please list all Allergies (life threatening and drug allergies) *

If none, please respond "N/A".

Do you have an Epipen?

Date of last Tetanus vaccination

Approximate, if necessary.

Please list any Past Surgery/Hospitalizations *

If none, please respond "N/A".

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Please list any/all medications, including the medication name, the reason for taking, dosage information, and time (i.e. Breakfast/AM, Lunch, Dinner, Bed/PM)

Medication Name

Dosage

Time(s) of Day Taken

Reason for Medication

ALL MEDICATION MUST BE IN ORIGINAL PHARMACY-LABELED CONTAINER AND MUST BE GIVEN TO OUR HEALTH SERVICE STAFF UPON ARRIVAL AND DISPENSED BY HIM/HER.

The following medications will be provided to the delegates if needed by the Heath Service staff.

Medication	Dose	Indication
Triple Antibiotic Ointment		Abrasions, superficial wounds
Wound wash	as needed	Wounds
Hydrocortisone cream	1%	Puritis / rash
Calamine Lotion		Puritis / rash
Aloe vera gel		Sunburn
Acetaminophen	dose per age/weight per label	Pain or fever
Ibuprofen	dose per age/weight per label	Pain or fever
Miralax	dose per age/weight per label	Constipation
Kaopectate	dose per age/weight per label	Diarrhea
Tums	dose per age/weight per label	Indigestion
diphenhydramine	dose per age/weight per label	Itching / reaction
Pseudoephedrine	dose per age/weight per label	Nasal congestion
Miconazole Powder		Pruritus/suspected fungal infection

Treatment Authorization

☐ **I approve the above-listed over the counter medications to be provided to the delegate as determined by the health staff.**

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Please list any medications from the above list that should not be administered.

In the event that the Delegate needs medical treatment and the parents/guardians cannot be reached, if a minor, the following person(s) may authorize treatment for the Delegate:

Authorized Alternate Contact #1 *

First *Last*

Authorized Alternate Contact #1 Phone Number

Relationship to Delegate *

Authorized Alternate Contact #2

First *Last*

Authorized Alternate Contact #2 Phone Number

Relationship to Delegate

If I and the above authorized individuals are not available to give consent, this signed statement will serve as authorization for World Affairs Seminar, the Program Sponsor, or any of its agents to provide, obtain, or authorize any reasonable incidental and/or emergency medical treatment for the Delegate, in the event of the Delegate's illness, injury, or incapacity.

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CONSENT AND ACKNOWLEDGMENT OF RISK *

In consideration of the right to attend and participate in the Program described above, the Delegate (and, if the Delegate is a minor, his or her parent or legal guardian) hereby:

1. Agrees to abide by all rules and regulations established by Carroll University, and World Affairs Seminar (Program Sponsor), and its service learning venues*;
2. Authorizes Carroll University, the World Affairs Seminar, its service learning venues*, or any of its agents to provide, obtain, or authorize any reasonable incidental and/or emergency medical treatment for the Delegate, in the event of the Delegate illness, injury, or incapacity, and hereby accepts the responsibility to pay for such treatment;
3. Grants to Carroll University and/or the World Affairs Seminar for any purpose connected with promoting the purposes and goals of Carroll University and/or the World Affairs Seminar, but not for commercial exploitation, the right to use the Delegate name, voice, and likeness in any writings, photographs, films, and recording of the Delegate while he or she is participating in the Program, and any biographical information submitted by the Delegate, 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 Delegate is physically, mentally, and emotionally capable of attending and participating in the Program; assumes all risk of and financial responsibility for any loss or injury to the Delegate or others that may occur as a result of the Delegate negligence or misconduct; and indemnifies and holds harmless Carroll University, the World Affairs Seminar, and service learning venues* from and against any and all costs, claims, demands, charges, liabilities, obligations, judgments, executions, costs of suit and actual attorneys' fees incurred or suffered by Carroll University, the World Affairs Seminar, or service learning venues* as a result of, or rising out of, the Delegate negligence or misconduct.

This consent and Acknowledgment of Risk shall not be amended, supplemented, or abrogated without the written consent of Carroll University, the World Affairs Seminar and service learning venues*.

*Service Learning Venues for the purpose of this Consent refers to a site or sites defined by World Affairs Seminar Staff where a group of Delegates is assigned for a portion of one day to experience some aspect of the Seminar's theme (shelter, food bank, nursing home) or explore resources not readily available on campus (another library, a museum, or a business or non-profit organization). Any service learning sites will be noted on the Seminar website by June 15. Assignment to a specific site will be by Seminar staff. These groups of Delegate will be accompanied by World Affairs Seminar Counselors and staff.

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

In addition, it is suggested that the delegate has a physical examination within the preceding 24 months.

☐ I accept the Terms and Conditions.

Delegate Signature *

Delegate Email Address *

A verification email will be sent to this email address.

Parent or Legal Guardian *

First Name

Last Name

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Parent or Legal Guardian Signature *

Parent or Legal Guardian Email Address

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