

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

Leave blank if same as legal name.

Last Name

Date of Birth *

MM/dd/yyyy

Sex *

☐ Female

☐ Male

☐ Other

Gender *

☐ Female

☐ Male

☐ Genderqueer/Non-Binary

☐ Other

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Pronouns

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

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

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

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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
- ☐ Other

Primary Parent/Guardian Name *

Title

First

Last

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.

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Additional Parent/Guardian Name

-Select-		
<i>Title</i>	<i>First</i>	<i>Last</i>

Relationship to Delegate

- ☐ Mother
- ☐ Father
- ☐ Grandparent
- ☐ Guardian
- ☐ Other

Additional Parent/Guardian Home Phone

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Additional Parent/Guardian Mobile Phone

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Additional Parent/Guardian Work Phone

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Do you have a primary care provider/physician (PCP)? *

- ☐ Yes
- ☐ No

Do you have any special dietary considerations or food allergies? *

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

Do you need any physical, emotional, cognitive, behavioral, or educational accommodations while attending the seminar? *

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

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Check any/all conditions that apply to you

- ☐ ADD/ADHD ☐ Anxiety/Depression ☐ Asthma ☐ Autism Spectrum Disorder ☐ Cancer
- ☐ Convulsions / seizures ☐ Diabetes ☐ Hearing/ Vision Loss ☐ Heart Problems ☐ High Blood Pressure
- ☐ Migraines ☐ None ☐ Other

Select all that apply.

Allergies

Allergen/Source

Reaction

Severity

Treatment Plan

Other Comments/Notes

Please list all allergies (include food, drug, insect, seasonal, life threatening, and other allergies)

Date of last Tetanus vaccination

MM/dd/yyyy

Approximate, if necessary.

Are you up-to-date on immunizations/vaccines? *

- ☐ Yes
- ☐ No

If available, please upload your complete vaccination record.

 sample.pdf

If available, please upload your most recent (within the last 24 months) annual physical assessment record.

 sample.pdf

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Please list any Past Surgery/Hospitalizations *

If none, please respond "N/A".

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

Name of Medication	Dosage	Frequency	Time(s) of day to be taken	Route

Medication Consent *

By listing your medications and completing this form, you understand that:

- All vitamins, minerals and prescription medications shall be in pharmacy-labeled containers that are clearly labeled to include the name of the delegate, the name of the medication, the dosage, the frequency of administration and the means of administration.
- All vitamins, minerals and medications **must** be given to our health service staff upon arrival and dispensed by him/her.
- Any over-the-counter medications not listed on signed form or in its original packaging will be collected and securely stored by the nursing team during the seminar and returned upon check-out.
- Any medications not listed on or submitted via the signed health form will **not** be able to be administered.

☐ I understand and consent.

PARENTS/GUARDIANS: If your child has a **rescue** medication, inhaler, epipen, or insulin, do you grant your child permission to carry it on their person during the seminar week?

- ☐ Yes
- ☐ No
- ☐ Does Not Apply

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

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Medication	Indication
Antibiotic Ointment	Abrasions, superficial wounds
Saline	Eye rinse
Cetirizine (Zyrtec)	Antihistamine/allergies
Hydrocortisone cream 1%	Pruritus / rash
Calamine Lotion	Pruritus / rash Poison oak/poison ivy
Aloe vera gel	Sunburn/burns
Acetaminophen (Tylenol)	Pain or fever
Ibuprofen	Pain or fever
Polyethylene glycol (MiraLAX)	Constipation
Aluminum-magnesium hydroxide -simethicone (Maalox or Mylanta)	Abdominal discomfort
Cough Drops	Soothe sore throat
Calcium Carbonate (TUMS)	Indigestion
diphenhydramine (Benadryl)	Itching / reaction
Phenylephrine	Nasal congestion
Miconazole powder	Pruritus / suspected fungal infection
Guaifenesin (Mucinex)	expectorant / cough
IcyHot	Muscle rub

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Treatment Authorization

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

☐ Yes

☐ No

If you select "no", an additional field will prompt you to list any exceptions or notes.

Do you authorize WAS staff to dispense sunscreen or bug spray to the registrant during the seminar week?*

☐ Yes, I authorize.

☐ No, I do not authorize.

☐ Other

Authorized Contacts

Name of Authorized Contact

Authorized Contact's Phone
Number

Relationship to Delegate

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. (At least 1 must be listed, up to 5).

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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, including transportation, 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's 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's 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

A verification email will be sent to this email address.

Who will receive copies of this submission?

When you click "submit" on this form, copies of this form will automatically be sent to the World Affairs Seminar staff registrar, to be shared with our licensed medical and nursing team. Copies of this response will also be sent via email to you (the registrant/delegate) and your listed primary parent/guardian.