World Affairs Seminar

CONSENT AND ACKNOWLEDGMENT OF RISK

Program: **World Affairs Seminar 2018 "Innovation, shaping the WORLD you will INHERIT"**

Camp Site/Name: **Carroll University**

Date of Session: **June 23 - June 29, 2018**

Delegate Name: ____

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) "Innovation" 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.

Parent or Legal Guardian: ____

Address: ____

Telephone: ______________________ Date: ______________________

Signature of Parent or Legal Guardian of Delegate: ______________________

World Affairs Seminar/housed at Carroll University –
HEALTH RECORDS

Please complete both sides of this form, supplying **ALL** requested information. In addition, it is suggested that the delegate has a physical examination within the preceding 24 months.

PLEASE TYPE OR USE INK AND PRINT CLEARLY

DELEGATE Name: ____
First Middle Last

Sex (circle one): Male Female __________ Date of birth: _________Place of Birth:_____________

Permanent Home Address: ____

____ Telephone: ____________________
City State Zip Code

Cell Phone # Delegate will carry during the Seminar _(___)________________________

PARENT/GUARDIAN INFORMATION

	Mother/Guardian	Father/Guardian
Name	____________________	____________________
Address	____________________	____________________
Home Phone	____________________	____________________
Employer	____________________	____________________
Work Phone	____________________	____________________

HEALTH CONCERNS:

Do you require any special dietary considerations? Please detail: ______________________________

____

Are there any physical exercise limitations that you can engage in? Yes ______ No ________

Describe:____

Check the conditions that you have:

____ Asthma
____ Convulsions / seizures
____ Diabetes
____ Hearing/ Vison Loss
____ Heart Problems
____ High Blood Pressure
____ Other: ____

Allergies (life threatening and drug allergies): List ______________________________________

Date of last Tetanus vaccination ________________
Past Surgery/Hospitalizations: ____

Name of Medication	Reason for Medication	Dose	Time (Breakfast/AM, Lunch, Dinner, Bed time/PM)

ALL MEDICATION MUST BE IN ORIGINAL 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 as 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 medications to be provided to the delegate **or** please list those medications that **should not** be used____.

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

Name/Relationship ____________________________________ Phone __________________

Name/Relationship ____________________________________ Phone __________________

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.

____ __________________________

Signature of Parent (***or*** Delegate if age 18 or over) ***Date***