

World Affairs Seminar

CONSENT AND ACKNOWLEDGMENT OF RISK

Program: **World Affairs Seminar 2012**

Camp Site/Name: **Carroll University**

Date of Session: **June 16-22, 2012**

Participant Name: _____

In consideration of the right to attend and participate in the Program 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 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 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 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 participant's name, voice, and likeness in any writings, photographs, films, and recording of the Participant while he or she is participating in the Program, and any biographical information submitted by the Participant, 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 Program; 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 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 Participant'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 students is assigned for a portion of one day to experience some aspect of the Seminar's theme: Sustainable Development. For example, some students may be going into water to collect water quality samples, others may be touring recycling facilities or industrial buildings that are being revitalized and/or doing a waste cleanup, while others may participate in an urban farming site. These groups of students will be accompanied by World Affairs Seminar Counselors and staff.

The Participant (and, if the Participant 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 Participant: _____

Student Last Name _____

First Name _____

World Affairs Seminar/housed at Carroll University – 6/16/12 – 6/22/12
RECORD OF MEDICAL HISTORY

For our records, and for your protection, please complete both sides of this form, supplying ALL requested information. In addition, Wisconsin law mandates that all participants shall have had a physical examination within the preceding 36 months. The proper signatures on this form indicate compliance with this state regulation. This form requires the signature of the participant and that of parent or legal guardian if participant is a minor.

PLEASE TYPE OR USE INK AND PRINT CLEARLY

PARTICIPANT

Name: _____
Last First Middle

Sex: _____ Date of birth: _____ Place of Birth: _____

Permanent Home Address: _____

City State Zip Code Telephone: _____

PARENT/GUARDIAN INFORMATION

	Mother/Guardian	Father/Guardian
Name	_____	_____
Address	_____	_____
Home Phone	_____	_____
Employer	_____	_____
Work Phone	_____	_____
Insurance Co.	_____	_____
I.D. Number	_____	_____

DOCTOR INFORMATION

Child's Doctor _____ Telephone _____

Child's Dentist _____ Telephone _____

Student Last Name _____

First Name _____

MEDICAL HISTORY

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. ALL MEDICATIONS MUST BE GIVEN TO OUR HEALTH SERVICE DIRECTOR UPON ARRIVAL AND DISPENSED DAILY BY HIM/HER.

Parent/Guardian Signature _____

Student Last Name _____

First Name _____

RECORD OF MEDICAL HISTORY

Check the following conditions you have had or are subject to:

Asthma _____	Hay Fever _____	Headache _____
Digestive Upsets _____	Fainting Spells _____	Convulsions _____
Hearing Loss _____	Vision Loss _____	Nose Bleeds _____

Check the following conditions you have had:

Measles _____	Diphtheria _____	Mononucleosis _____	Tonsillectomy _____
Mumps _____	Epilepsy _____	Chicken Pox _____	Appendectomy _____
Pneumonia _____	Polio _____	German Measles _____	Heart Problems _____
Heart Disease _____	Diabetes _____	Seizures _____	Other _____

What vaccinations and immunizations have you had?

	Yes	No	Date (Month/Year)	Please list known allergies
Diphtheria, Tetanus				
Polio				
Measles				
Rubella (German Measles)				
TB Skin Test				

GENERAL

1. Do you require any special dietary considerations? Please detail: _____

2. Are there any limitations on the amount or type of physical exercise that you can engage in?

Yes _____ No _____

Describe: _____

TREATMENT AUTHORIZATION

In the event that the Participant is a minor and needs medical treatment, I request that the parents/guardians listed on the form be contacted to authorize treatment. In the event parents/guardians cannot be reached, the following persons have been given consent to authorize treatment for the Participant:

Name/Relationship _____ Phone _____

Name/Relationship _____ Phone _____

PARENTAL CONSENT FOR TREATMENT OF A MINOR

If a situation occurs in which the above named Participant is a minor and requires immediate medical attention, and I [or an authorized individual(s)] am unable 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 Participant, in the event of the Participant's illness, injury, or incapacity.

Signature of Parent
(if participant is a minor)

Date