



May 24<sup>th</sup>, 2010

Dear JUFA,

Enclosed are the three documents required to be filled out and signed for you to volunteer at Iowa HOBY. The only other form required will be the Code of Conduct for Staff Members which you will sign when you check in at Iowa HOBY on Thursday June 10<sup>th</sup>, 2010.

Please postmark all paperwork by June 1<sup>st</sup>, 2010 to the mailing address provided on the top of each form. All paperwork must be submitted prior to June 10<sup>th</sup>, 2010 in order for you to be at the Iowa HOBY Seminar.

1. **Medical History Records Form (2 pages)**
2. **Consent & Acknowledgment of Risk Form—MUST BE NOTARIZED!**
3. **Notice of Privacy Practices**

Please contact me with any questions leading up to the seminar. Thank you for volunteering!

Sincerely,

Amber Keehn  
Director of Junior Staff  
[juniorstaff@iahoby.org](mailto:juniorstaff@iahoby.org)  
(712) 310-1270

10880 Wilshire Boulevard - Suite 410  
Los Angeles, CA 90024  
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Please postmark this form by June 1st, 2010 to:  
**Amber Keehn**  
 9343 Wilson Street  
 West Des Moines, IA 50266

## 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:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Chicken Pox              | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Diphtheria               | <input type="checkbox"/> Mumps         | <input type="checkbox"/> Tonsillitis     |
| <input type="checkbox"/> German Measles (Rubella) | <input type="checkbox"/> Polio         |  |
| <input type="checkbox"/> Measles                  | <input type="checkbox"/> Pneumonia     |  |

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

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Anxiety                  | <input type="checkbox"/> Ear Infection   | <input type="checkbox"/> Nose Bleed          |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Epilepsy        | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> ADD/ADHD                 | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Difficulty Sleeping |
| <input type="checkbox"/> Bleeding tendencies      | <input type="checkbox"/> Hay Fever       | <input type="checkbox"/> Upset stomache      |
| <input type="checkbox"/> Emphysema/ Bronchitis    | <input type="checkbox"/> Headache        | <input type="checkbox"/> Vision Loss         |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Heart Disease   | <input type="checkbox"/> Other _____         |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Hearing Loss    | <input type="checkbox"/> Other _____         |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Migraine        |  |

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; use additional sheet if necessary. \_\_\_\_\_

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, including vegetarianism. \_\_\_\_\_

## Medical History Records Form (page 2)

### MEDICATION

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

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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 or completed Medication Verification Form for Physicians to the seminar.** 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.

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

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

### IMMUNIZATIONS

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

Type of Illness:	Approximate Date(s) of Immunization:
<input type="checkbox"/> Hepatitis B	
<input type="checkbox"/> DPT (Diphtheria, Pertussis, Tetanus)	
<input type="checkbox"/> Tetanus booster (Please indicate date of last booster)	
<input type="checkbox"/> Hib (Haemophilus influenzae type B)	
<input type="checkbox"/> Polio	
<input type="checkbox"/> MMR (Measels, Mumps, Rubella)	
<input type="checkbox"/> Chicken pox (Varicella)	
<input type="checkbox"/> Influenza (Flu shot)	
<input type="checkbox"/> Pneumonia (Pneumococcal)	
<input type="checkbox"/> Meningitis (Meningococcal)	
<input type="checkbox"/> Smallpox	
<input type="checkbox"/> 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 Parent/Legal Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Participant:** \_\_\_\_\_ **Date:** \_\_\_\_\_



Please postmark this form by June 1st, 2010 to:  
**Amber Keehn**  
 9343 Wilson Street  
 West Des Moines, IA 50266

## Consent & Acknowledgement of Risk Form

**(This has to be NOTARIZED in order to attend seminar)**

(Please type or print legibly)

Participant's Name: \_\_\_\_\_

Event/Activities: Iowa HOBY Leadership Seminar

Dates: Thursday, June 10 to Sunday, June 13, 2010 Location: Central College in Pella, Iowa

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 attorneys' fees incurred or suffered by HOBY as a result of, or arising out of, the Participant's negligence 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 Acknowledgment 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: \_\_\_\_\_



Please postmark this form by June 1st, 2010 to:  
**Amber Keehn**  
 9343 Wilson Street  
 West Des Moines, IA 50266

## 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 818-851-3980.

### 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 818-851-3980.

### 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: \_\_\_\_\_