Permission forms for participation in Power of Hope Camp at Commonweal 2016

My child is attending the following camp:
☐ Power of Hope at Commonweal, July 13-20, 2016

Dear Parent or Guardian,

Please fill out the following forms and return them to:

Commonweal Power of Hope
attn: Amber Faur
PO Box 316
Bolinas, CA 94924

If you have any questions, please contact amber@commonweal.org or call her at 415-779-1018 (office)

Medical and Emergency Permission Form

I hereby give permission that I/my child may be given emergency treatment by a qualified staff member of PYE/Power of Hope/Commonweal. I also give permission for me/my child to be transported by ambulance or aid car to an emergency center for treatment. In the event that the participant's emergency contact cannot be reached, I further consent to the medical, surgical, and hospital care, treatment, and procedures to be performed for me/my child by a licensed physician or hospital selected by the PYE/Power of Hope/Commonweal staff when deemed immediately necessary or advisable by the physician to safeguard my/my child's health. I have read, understand, and agree to the above listed statement and do sign this agreement of my own free will.

Signature of parent/legal guardian:_____

Print Name:_____

Date: _____

Hold Harmless Parental Release Form for Commonweal Power of Hope Camp

This information is necessary for your participation in the Commonweal Power of Hope Camp. ***Each line must be initialed by a parent or guardian****. Participants who are 18 years of age may complete this form themselves.*

Please initial each statement and sign below:

I permit my youth to participate in the Commonweal Power of Hope camp on August 7-14, 2015. _____

I hereby hold harmless PYE/POH/Commonweal/Destiny Arts, its employees, officers and agents, funders, and landlords, and any leaders of these organizations from any and all responsibility and liability of any nature that may arise during the camp from circumstances beyond these organizations' control. _____

I hereby hold harmless PYE/POH/Commonweal/Destiny Arts, its employees, officers and agents, and any leaders of these organizations from any and all responsibility and liability of any nature which may arise if the named participant leaves the grounds of the program without authorization, or otherwise goes against the basic program guidelines listed on the application form. _____

Insurance: It is the responsibility of every participant, their parent or legal guardian to provide their own accident and health coverage while participating in all Commonweal Power of Hope activities. I understand that Commonweal Power of Hope does not provide any accident or health coverage for its participants. ____

Participation: I give permission for my child to participate in activities, field trips, and swimming and to be transported in vans or private automobiles as authorized by Commonweal, PYE, Destiny Arts or Power of Hope. _____

Valuables: We ask that youth do not bring cell phones, I-PODS, CD players, headsets or other equipment to camp unless they are needed for travel. Participants will be asked to check any valuables in with the camp manager for safe keeping at registration. This includes electronic equipment, passports, money, and any other valuables. Participants will not need any money during the camp. I understand that my youth needs to check in valuables with the camp manager at registration and that Commonweal, PYE, Destiny Arts, Power of Hope cannot take responsibility for any missing valuables at camp. _____

Photo Release: I give permission for PYE/Commonweal/Power of Hope/Destiny Arts or those who have the written consent of PYE/Commonweal/Power of Hope/Destiny Arts to use photo or videos of my child for purposes of promoting future Power of Hope programs. I expressly release PYE/Power of Hope/Commonweal/Destiny Arts, your agents, employees, licensees, and assigns from any and all claims in which I have or may have for invasion of privacy, defamation, or any other cause of action arising out of the use of these photographs and video. _____

Does this youth: Please indicate whether the participant has a history of behavioral or other problems such as substance abuse, involvement with the criminal justice system or mental health issues.

No _____ Yes _____ If yes, please elaborate in writing or by phone

Behavioral Guidelines

Although the Commonweal Power of Hope Camp helps youth make positive decisions, it is NOT a treatment program. Within the clearly defined boundaries and structures of the program, youth have many opportunities to make choices at camp. As such, youth who are unable to manage their behavior without full-time supervision are not appropriate for this program. We cannot accept youth who have a history of running away from programs, or who have exhibited any predatory sexual behavior or other behaviors that put themselves or others at risk. It is incumbent on you to speak with us if you have any questions about whether a particular youth is appropriate for this program.

I have read, initialed, and understand the above terms and have completed this form to the best of my ability.

Participant's Name: _____

Participant's Signature (if 18 or over): _____**Date:** _____

Parent or Guardian Name (Please Print): _____

Parent or Guardian Signature: _____

Date: _____

General Information/Health History

Full name: _____

DOB: _____

Age: _____ Gender: _____ Height (inches): _____ Weight (lbs.): _____

Address: _____

City: _____ State: _____ ZIP code: _____ Telephone: _____

Unit leader: _____ Mobile phone: _____

Council Name/No.: _____ Unit No.: _____

Health/Accident Insurance Company: _____ Policy No.: _____

Please attach a photocopy of both sides of the insurance card. If you do not have medical insurance, enter "none" above.

In case of emergency, notify the person below:

Name: _____ Relationship: _____

Address: _____ Home phone: _____ Other phone: _____

Alternate contact name: _____ Alternate's phone: _____

Health History

Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Explain
☐	☐	Diabetes	**Last HbA1c percentage and date**:
☐	☐	Hypertension (high blood pressure)	
☐	☐	Adult or congenital heart disease/heart attack/chest pain (angina)/heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
☐	☐	Family history of heart disease or any sudden heart-related death of a family member before age 50.	
☐	☐	Stroke/TIA	
☐	☐	Asthma	**Last attack date**:
☐	☐	Lung/respiratory disease	
☐	☐	COPD	
☐	☐	Ear/eyes/nose/sinus problems	
☐	☐	Muscular/skeletal condition/muscle or bone issues	
☐	☐	Head injury/concussion	
☐	☐	Altitude sickness	
☐	☐	Psychiatric/psychological or emotional difficulties	
☐	☐	Behavioral/neurological disorders	
☐	☐	Blood disorders/sickle cell disease	
☐	☐	Fainting spells and dizziness	
☐	☐	Kidney disease	
☐	☐	Seizures	**Last seizure date**:
☐	☐	Abdominal/stomach/digestive problems	
☐	☐	Thyroid disease	
☐	☐	Excessive fatigue	
☐	☐	Obstructive sleep apnea/sleep disorders	**CPAP: Yes** ☐ **No** ☐
☐	☐	List all surgeries and hospitalizations	**Last surgery date**:
☐	☐	List any other medical conditions not covered above	

General Information/Health History

Full name: _____

DOB: _____

Allergies/Medications

Are you allergic to or do you have any adverse reaction to any of the following?

Yes	No	Allergies or Reactions	Explain
☐	☐	Medication	
☐	☐	Food	

Yes	No	Allergies or Reactions	Explain
☐	☐	Plants	
☐	☐	Insect bites/stings	

List all medications currently used, including any over-the-counter medications.

☐ **CHECK HERE IF NO MEDICATIONS ARE ROUTINELY TAKEN.**

☐ **IF ADDITIONAL SPACE IS NEEDED, PLEASE INDICATE ON A SEPARATE SHEET AND ATTACH.**

Medication	Dose	Frequency	Reason

☐ **YES** ☐ **NO** **Non-prescription medication administration is authorized with these exceptions:**_____

Administration of the above medications is approved for youth by:

_____ / _____

Parent/guardian signature **MD/DO, NP, or PA signature (if your state requires signature)**

! **Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication unless instructed to do so by your doctor.** **!**

Immunization

The following immunizations are recommended by the BSA. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

Yes	No	Had Disease	Immunization	Date(s)
☐	☐	☐	Tetanus	
☐	☐	☐	Pertussis	
☐	☐	☐	Diphtheria	
☐	☐	☐	Measles/mumps/rubella	
☐	☐	☐	Polio	
☐	☐	☐	Chicken Pox	
☐	☐	☐	Hepatitis A	
☐	☐	☐	Hepatitis B	
☐	☐	☐	Meningitis	
☐	☐	☐	Influenza	
☐	☐	☐	Other (i.e., HIB)	
☐	☐	☐	Exemption to immunizations (**form required**)	

Please list any additional information about your medical history:

DO NOT WRITE IN THIS BOX

Review for camp or special activity.

Reviewed by:_____

Date: _____

Further approval required: ☐ Yes ☐ No

Reason: _____

Approved by:_____

Date: _____

Pre-Participation Physical

This part must be completed by certified and licensed physicians (MD, DO), nurse practitioners, or physician assistants.

Full name: _____

DOB: _____

You are being asked to certify that this individual has no contraindication for participation inside a Scouting experience. For individuals who will be attending a high-adventure program, including one of the national high-adventure bases, please refer to the supplemental information on the following pages or the form provided by your patient.

Examiner: Please fill in the following information:

	Yes	No	Explain
Medical restrictions to participate	☐	☐	

Yes	No	Allergies or Reactions	Explain	Yes	No	Allergies or Reactions	Explain
☐	☐	Medication		☐	☐	Plants	
☐	☐	Food		☐	☐	Insect bites/stings	

Height (inches):_____ **Weight (lbs.):**_____ **BMI:**_____ **Blood Pressure:**_____/_____ **Pulse:**_____

	Normal	Abnormal	Explain Abnormalities
Eyes	☐	☐	
Ears/nose/ throat	☐	☐	
Lungs	☐	☐	
Heart	☐	☐	
Abdomen	☐	☐	
Genitalia/hernia	☐	☐	
Musculoskeletal	☐	☐	
Neurological	☐	☐	
Other	☐	☐	

Examiner's Certification

I certify that I have reviewed the health history and examined this person and find no contraindications for participation in a Scouting experience. This participant (with noted restrictions):

True	False	Explain
☐	☐	Meets height/weight requirements.
☐	☐	Does not have uncontrolled heart disease, asthma, or hypertension.
☐	☐	Has not had an orthopedic injury, musculoskeletal problems, or orthopedic surgery in the last six months or possesses a letter of clearance from his or her orthopedic surgeon or treating physician.
☐	☐	Has no uncontrolled psychiatric disorders.
☐	☐	Has had no seizures in the last year.
☐	☐	Does not have poorly controlled diabetes.
☐	☐	If less than 18 years of age and planning to scuba dive, does not have diabetes, asthma, or seizures.
☐	☐	**For high-adventure participants, I have reviewed with them the important supplemental risk advisory provided.**

Examiner's Signature:_____ **Date:** _____

Provider printed name:_____

Address: _____

City:_____ State: _____ ZIP code: _____

Office phone: _____

Height/Weight Restrictions

If you exceed the maximum weight for height as explained in the following chart and your planned high-adventure activity will take you more than 30 minutes away from an emergency vehicle/accessible roadway, you may not be allowed to participate.

Maximum weight for height:

Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight
60	166	65	195	70	226	75	260
61	172	66	201	71	233	76	267
62	178	67	207	72	239	77	274
63	183	68	214	73	246	78	281
64	189	69	220	74	252	79 and over	295