



# Annual Participation Authorization (PRO-3)

Please return this form to your Regional Office.

Participant's Full Name: \_\_\_\_\_ Grad Year: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_ Chapter: \_\_\_\_\_

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 F

Parent/Guardian 1 Name: \_\_\_\_\_

Day Phone : \_\_\_\_\_ Night Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-mail: \_\_\_\_\_

Parent/Guardian 2 Name (optional): \_\_\_\_\_

Day Phone : \_\_\_\_\_ Night Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-mail: \_\_\_\_\_

I/We the undersigned have legal custody of the participant named above, a minor, and have given our consent for \_\_\_\_\_ to participate in the activities of BBYO for the program year of 200\_\_.

I give my permission to engage in all activities except as noted on the back of this form. I understand that I am responsible for arranging transportation to and from events (even if dismissed prior to the official end of the event because of unruly behavior). I authorize BBYO to publish photographs/video taken of my son/daughter, his/her name and any quotations that he/she provides for use in printed publications, presentations, mailed promotions, exhibits, press releases, video, CDs, DVDs and websites. Since participation in photography/videos produced by BBYO is voluntary, neither my child nor I will receive any financial compensation. I further agree that participation in any photography/videos produced by BBYO confers no rights of ownership whatsoever. Any photograph/video/quote taken may be shared with BBYO partners while carrying forth these provisions.

**Note: all overnight program requires a separate teen consent form and parental release form to be signed.**

In case of medical emergency, I understand that every effort will be made to contact the parent or guardian. In the event that I cannot be reached, I hereby authorize and consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any licensed medical personnel on the staff of any licensed hospital. This authorization is given in advance of any specific diagnosis, treatment or hospital care required, but is given to provide authority and power to render care which is deemed advisable in the best judgment of the physician. I am responsible for payment of all fees incurred.

I hereby indemnify, agree to hold harmless, and waive any claim against BBYO, Inc., its representatives, officers, agents, employees, directors, and each of them, for any and all past, present or future loss to property, and/or bodily injury resulting from any activities engaged.

Parent/Guardian

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to the Participant: \_\_\_\_\_

Parent/Guardian

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to the Participant: \_\_\_\_\_

**EMERGENCY CONTACT PERSONS (other than parents/guardians)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_



# Participant Medical Information and Consent to Treat

Please return this form to your Regional Office.

Full Name of Minor: \_\_\_\_\_

Birth Date of Minor: \_\_\_\_\_ Date of Last Tetanus Shot: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

**If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability, or condition to which your child is subject and of which the staff should be aware, and what, if any action of protection is required on account thereof. Submit this notification in writing and attach it to this form.**

I acknowledge that BBYO's Medication Management policy strongly recommends any overnight program participant to turn in all medication to the BBYO staff upon arrival. If collected, the BBYO staff will administer the medication in the proscribed manner in accordance with the instructions provided below. The medication will be returned to the participant upon departure. In order to properly and legally administer medication that you send with your child, you must complete all the information below.

Name of Med:	Purpose & Dosing instructions:	Special care required:
_____	_____	_____
_____	_____	_____
_____	_____	_____

### Other medical facts we should know:

If the program your child is attending is a regional or International program, your child may visit the health center and be prescribed a single dose or short-duration course of either a prescription or OTC medication, at the physician's discretion. However, if there are any types of medications you want your child to avoid, please list:

Check the following areas of concern for this participant. If necessary, add another page with details.

1. Does your child have allergies to any of the following?

- pollens  medications  food  insect bites

2. Does your child suffer from, or has ever experienced, or is being treated currently for any of the following?

- asthma  epilepsy / seizure disorder  heart trouble  diabetes  
 frequently upset stomach  disability

Please list and explain any major illnesses the child experienced during the last year:

Should this child's activities be restricted for any reason? Please explain:

Special needs (including dietary):

\* Please remember to update the local office throughout the year if any information on this form changes.