

Freedoms Foundation at Valley Forge

Student Information Form

(Must be printed or typed)

Full Name: _____

Birth Date: _____ Please mark one Male Female

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Student Cell Phone: _____

Student E-Mail: _____

Name of Parents/Guardians: _____

Conference Date: February 20-23, 2020

School Information

Name of School: _____

Address of School: _____

Grade Level: 9 10 11 12

Academic Ranking: Top10% Top 20% Top 30% Top 50%

Personal Information

Organizational Memberships: _____

Leadership Positions Held: _____

Hobbies//Sports/Travel: _____

FREEDOMS FOUNDATION AT VALLEY FORGE
STUDENT MEDICAL INFORMATION FORM

Please include a photocopy of the student's health insurance card.

This form consists of FOUR sections. In order to be admitted to the Spirit of America Youth Leadership Program, each section needs to be completed with the required signatures and returned to Freedoms Foundation by February 6, 2020.

NAME OF PARTICIPANT _____

I. PARENT'S WAIVER

We (I) hereby give permission for the above named student to attend the Spirit of America Youth Leadership program on February 20-23, 2020 to be conducted at Freedoms Foundation at Valley Forge. We (I) hereby release and discharge the Freedoms Foundation at Valley Forge, its officers, agents, instructors and employees, from any and all claims, demands, suits, actions or causes of action which we (I) may or shall have reason of any illness, injury or accident incurred or suffered by the above named participant at this conference and in the course of travel by any means to and from and while on the premises of the Freedoms Foundation at Valley Forge, no matter how caused or occasioned.

Names of Parents or Guardians (Please print)

Date

Signature of Parents/Guardians

Telephone: Home _____ **Cell** _____

Parents/Guardians E-Mail _____

I. INSURANCE

Freedoms Foundation does not carry medical insurance to cover participants. All participating students should be covered by personal or family insurance.

We (I) hereby certify, under penalty of perjury, that the above named student is covered by medical insurance.

Names of Parents or Guardians (Please print)

Date

Signature of Parents/Guardians

Insurance Company _____

Policy/Group number _____

Expiration Date of insurance _____

Please list emergency number(s) other than those above at which parent, guardian, or another relative may be reached during the conference.

(Please print and relationship to student)

Name _____ **Telephone** _____

Name _____ **Telephone** _____

II. PARENTS CONSENT FOR EMERGENCY MEDICAL TREATMENT

In the event that our (my) child _____ becomes ill or sustains an injury while under the supervision of the Freedoms Foundation staff, we (I) hereby give permission to administer first aid for our (my) child's relief. If it is not practical to return our (my) child to us (me), or to receive our (my) instructions for his/her care, consent is given to any licensed physician and/or surgeon to whom our (my) child is taken for treatment, to administer such treatment, drugs, and medicines and to perform such surgical procedures as the licensed physician and/or surgeon shall think the existing emergency requires for the relief of pain, and to preserve our (my) child's life and health. We (I) understand and agree that while the Freedoms Foundation staff may seek medical treatment for our (my) child, we (I) hereby release and discharge the Freedoms Foundation, its officers, agents, instructors and employees, for any and all demands, suits, actions or causes of actions that we (I) may or shall have by reason of arranging for such medical treatments or from failure to seek such medical treatments.

Names of Parents or Guardians (Please print)

Signature of Parents/Guardians

Date

III. STUDENTS MEDICAL HISTORY

Name of Participant _____ Birth Date _____

Address _____

City _____ State _____ Zip Code _____

Date of most recent exam _____ Weight _____ Height _____

Date of most recent tetanus toxoid immunization _____

Doctor's Name _____

Doctor's Address _____

City _____ State _____ Zip Code _____

Doctor's Telephone _____

HEALTH HISTORY

Please provide any information about a student's health history that may impact their participation in the program. This may include health concerns, food and medication allergies (see below), and/or current medications (see below). Attach additional pages if necessary.

CONDITIONS

- Frequent ear infections
- Heart defect/disease
- Convulsions
- Diabetes
- Bleeding/Clotting disorders
- Hypertension
- Mononucleosis
- Hepatitis

ALLERGIES

- Hay Fever
- Ivy poisoning, etc.
- Insect Stings
- Asthma
- Penicillin
- Other Drugs

IMMUNIZATIONS

- Chicken Pox
- Measles
- Mumps
- Rubella
- DTaP

Food Allergies _____

Current Medication taking _____

Medication allergies _____

List any condition or illness that Freedoms Foundation should be aware of that is not mentioned _____

THANK YOU FOR PROVIDING US WITH THIS INFORMATION.

Honor Code

As a participant in the Spirit of America Youth Leadership Program, I agree to:

- ❧ Participate in all activities to the fullest extent possible.
- ❧ Be on time to all scheduled events.
- ❧ Show respect to my fellow participants, adults leaders, and myself.
- ❧ Leave the campus—classrooms, dormitories, dining hall, etc... - in the same condition I found them.
- ❧ Follow all rules and instructions as communicated by the program director and staff.
- ❧ Honor wake up time and lights out times.
- ❧ Behave in a way that is always safe for me and others.
- ❧ Make this weekend alcohol, tobacco, and drug free.

Participant signature

Date

Freedoms Foundation at Valley Forge Talent Release Form

ASSIGNMENT, CONSENT, AND RELEASE

I, the undersigned, on behalf of my child, _____, hereby grant absolute right and permission to Freedoms Foundation at Valley Forge to take photographs, video, testimonials and/or audio reproductions of the person(s) named above and to copyright, use, publish, and distribute same.

In granting such permission, I hereby relinquish any right, title or interest in such photographs, video, testimonials, CD ROMs, DVDs, and/or audio reproductions and grant Freedoms Foundation at Valley Forge permission to publish, exhibit or use such audio/visuals for any and all promotional purposes stated, including broadcast, website, and other print and/or electronic uses.

I, the undersigned, certify that I am 18 years or older and have read this release and understand all its terms. I execute it voluntarily and with full knowledge of its significance.

Name of Parent/Guardian

Signed

Date

Address

Freedoms Foundation at Valley Forge

Spirit of America Youth Leadership Program

Must be returned to Freedoms Foundation by February 6, 2020 & must complete both sections!

ARRIVAL

Freedoms Foundation will provide transportation from the Philadelphia Airport, 30th Street Train Station or Paoli Train Station to the Foundation's campus ONLY if you arrive between 12:00 noon and 5 p.m.

DATE OF ARRIVAL: _____

Airline and Flight Number _____

Time of Arrival: _____ Originating City _____

30th Street Train Number _____ Time of Arrival _____

Car _____ Time of Arrival _____

Please provide the student's cell phone number so we may contact them if we are not able to locate them at the Philadelphia Airport or Train Station on arrival day!

Cell # _____

DEPARTURE

At the conclusion of the conference, Freedoms Foundation will provide transportation to the airport or train station ONLY if you scheduled your departure after 2:30 p.m. (Special arrangements for departures prior to 2:30 p.m. must be made with the Freedoms Foundations staff before the conference begins.)

DATE OF DEPARTURE – _____

Airline and Flight # _____ Time of Departure _____

30th Street Train Number _____ Time of Departure _____

Car _____ Time of Departure _____

**STUDENTS, PLEASE RETURN COMPLETED FORM
TO FREEDOMS FOUNDATION
BY FEBRUARY 6, 2020**