



Please return this form by June 8th to:
 Robert Santos
 Fax: (213)430-2626
 10736 Jefferson Boulevard #714
 Culver City, CA 90230

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:

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.

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



Policy for Use of Medication During a HOBY Event

If a minor or adult participant is required to take medication during a HOBY event, including the HOBY Leadership Seminar, he/she must comply with the following guidelines:

1. HOBY volunteers will not dispense prescription medication for participants during the event.
2. Any participant bringing prescription medication to the event must submit a doctor's note or completed Physician Medication Verification Form to HOBY, preferably in advance or at the event check-in, detailing the following:
 - a. The name and type of medication.
 - b. The condition for which the medication is being prescribed.
 - c. Dosage information.
 - d. Attestation that 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.

This information is necessary to provide medical personnel in the case of emergency and the participant is unable to communicate the information. All prescription medication must be submitted to HOBY in its original container as labeled by the pharmacy. HOBY will store required medications in a locked facility. The medications a participant may be allowed to keep in his/her possession is any asthma medications (inhalers, oral steroids, etc.), birth control pills, acne medication, any topical medications, allergy medications, medications for treatment of diabetes (insulin, etc.) and EpiPens, as well as any other prescription medication required by the doctor to be in their possession at all times. But there will need to be a doctor's note completed and on file for all medication brought to the event, whether stored or not.

If a participant fails to advise HOBY that he/she is taking prescription medication, is not taking the medication as prescribed, and/or has stopped taking prescription medication, HOBY reserves the right to send the participant home at the participant's guardian or parent's expense.

3. If the participant has a medical condition that requires any assistance, the assistance must be provided or contracted directly by the participant or his/her parent/guardian. Under no circumstances will a HOBY volunteer help with dispensing medication. If help is needed on an emergency basis, emergency personnel will be contacted.
4. Proper administration and dosage of medication shall be the sole responsibility of the participant. HOBY will have no responsibility in seeing that the participant takes the medication as prescribed by the doctor.
5. Participants should only bring as much medication as will reasonably be needed during the event.
6. Participants are prohibited from sharing their personal medication with another participant. Conversely, participants are prohibited from accepting medication from anyone, other than HOBY medical staff.
7. Any participant bringing illegal drugs, narcotics, misused prescription drugs and/or mood altering substances or alcoholic beverages to a HOBY event, using them on HOBY premises or dispensing or selling them on HOBY premises will be subject to disciplinary action, including automatic expulsion from the event. The discharged participant will be responsible for any charges/fees incurred as a result of leaving the event early (i.e. change in airfare, taxi, etc.). HOBY has a very strict/no-tolerance policy when it comes to drugs.



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Medication Verification Form for Physicians

(Please type or print legibly)

(This form is to be completed by the participant's prescribing physician. If the participant has more than one prescribing physician, then each physician will need to complete a form. Please type or print legibly.)

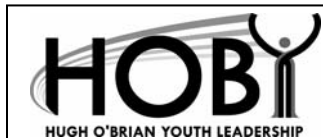
1. Name of Participant/Patient: _____
2. Prescribing Physician Name: _____
3. Prescribing Physician Medical License Number and State where licensed: _____
4. Please complete the chart below for the medications which you have prescribed to the participant.

Name of Medication	Type of Medication	Condition for Treatment	Dosage	Frequency

5. Please affix physician's business card or voided prescription in the space below.

As the prescribing physician, I attest that the use of the medications prescribed by me, and taken as directed as listed above, should 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.

Signature of Prescribing Physician: _____ Date: _____



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Health Insurance Form

(Please type or print legibly)

1. Name of Participant: _____
2. Health insurance plan name: _____
3. Health insurance plan number: _____
4. Health insurance group number: _____
5. Check here if participant is not covered by a health insurance plan.
6. Name of parent or legal guardian: _____
(Last) (First)
7. Emergency contact telephone number: _____
(Area Code)

Signature of Parent/Legal Guardian: _____ Date: _____

Please return this form by June 8th to:

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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 (310) 474-4370.

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

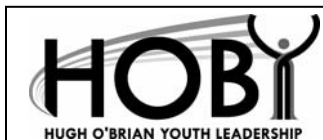
Questions or complaints about this Notice of Privacy or how HOBY maintains the medical information of your child or dependent should be directed to Hugh O'Brian Youth Leadership at (310) 474-4370.

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: _____



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Talent Show Form

(Please type or print legibly)

A Talent Show will be one of the scheduled events for the HOBY weekend. What's your talent? Are you a singer, dancer, instrumentalist, orator, magician, actress/actor, comedian? **If you enjoy entertaining others, then come entertain the HOBY crowd!**

Details of Talent Show:

1. Each act is limited to 2-3 minutes.
2. Limited audio/visual equipment will be available. Please bring the music you need.
3. A piano will be available.
4. No dress rehearsal time (don't worry.... when you're good, you're good!).

To Register:

Fill out this form and return it by the deadline listed above.

Full Name: _____

High School: _____

Home Phone: _____

E-mail: _____

Talent: _____

Props: _____

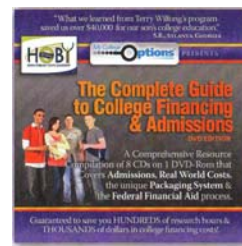


Attention Parents

HOBY has partnered with College Options Foundation (www.collegeoptions.net) to make *“The Complete Guide to College Financing and Admissions”* DVD Program available at the Los Angeles HOBY Leadership Seminar for parents, ambassadors, and alumni.

The DVD program covers the following topics:

- The College Selection and Admissions Process
- Key Interview and Essay Skills
- College Financial Aid & Packaging
- Scholarships
- Creative and Military Options for College Financing
- Student Planning Guide
- College Success



This DVD Program takes students and parents through the entire college selection, admissions, and financing process and includes amazing resources to help college-bound students in this often confusing and trying process.

The DVD will be available after the Closing Ceremony for \$35.

Payment can be made via check, (payable to HOBY); cash, or credit card (Visa, MasterCard, Discover or American Express). Each DVD sold helps support the Los Angeles HOBY seminar and HOBY International.

We are offering a special parent’s program on College Admissions and Finance as part of our Parent’s Program starting at 3:45 on June 21st at the Shannon Center at Whittier College followed by the Closing Ceremony

Here’s what a parent of a HOBY Ambassador had to say about the DVD program:

*Dear Terry,
I wanted to send you this note to thank you for the wonderful programs we received at HOBY. I cannot believe how much time the DVD will save us in the college search, and I have only just reviewed them! I know the potential must be HUGE, since I have only spent a short amount of time reviewing them, and already have a better plan!! I am amazed at how this program will help in taking the test. My daughter is bound to do better on her scores with this valuable information. Again, I would like to thank you for the awesome opportunity to save so much money in our college expenses, not to mention the time saved as well!
Sincerely, Marybeth Milton*