Partnering for Prevention, LLC ("PFP")
McHenry County Operation Snowball/Snowflake Consent Form

Participant Information

Gender: _____ Birth Date: _____ Age: _____ School: _____ Current Grade: _____

Name (First, Middle, Last): _____ Nickname_____

Address/City/State/Zip: _____

Home Phone: ( ) _____ Email: _____

Participant Cell Phone: ( ) _____

Legal Guardian Information – *MUST BE COMPLETED & SIGNED BY THE LEGAL GUARDIAN*

Name (First, Middle, Last): _____ **Relationship to Participant** _____

Address (If different than above): _____

Phone Numbers: Home ( ) _____ Wk ( ) _____ Cell ( ) _____

Name (First, Middle, Last): _____ **Relationship to Participant** _____

Address (If different than above): _____

Phone Numbers: Home ( ) _____ Wk ( ) _____ Cell ( ) _____

Legal Guardian Consent for Medical Treatment - I am the legal guardian of the participant named above. My signature below these provisions indicates that I agree with, accept and acknowledge the information contained in this document. I understand that first aid treatment will be available and, if necessary, the participant will be taken to the nearest hospital if he/she requires further medical attention. I hereby consent to the giving of first aid treatment and medical treatment described in this paragraph. I acknowledge that the Partnering for Prevention is not responsible for any medical bills incurred for any medical treatment provided to the participant while he/she is attending any Partnering for Prevention program. In case of an illness and/or injury of/to the participant, I hereby authorize Partnering for Prevention personnel to obtain necessary treatment. I also understand that if emergency treatment or surgery is necessary, Partnering for Prevention or medical personnel will attempt to notify me to obtain my approval. **If I am unavailable, I designate someone other than myself (named below) to give such consent:**

Name _____ Relationship to participant _____

Address/City/State/Zip: _____

Home Phone ( ) _____ Cell/Alternate Number _____

In the event those efforts to contact me or my designee are unsuccessful, I hereby authorize the attending physician to administer any treatment, including surgery, which he or she deems necessary. If Partnering for Prevention personnel determine that medical treatment of the participant is necessary, and I refuse to permit the participant to receive medical treatment, Partnering for Prevention reserves the right to request that I, the legal guardian, immediately pick up the participant and remove them from the program, and I agree to do so. My signature below indicates I have read the information regarding the Consent for Medical Treatment and I agree with, accept and acknowledge these provisions.

Signature of the Legal Guardian (required) _____ Date _____

OFFICE USE ONLY New to PFP: _____ Add to Mailing List: _____ Program: _____

Reviewed By: _____ Date: _____

Health Information - *Physician information must be complete*. Nondisclosure of requested information or omission of prescribed medication on this form is grounds for dismissal from any Partnering for Prevention programs. If the applicant is hospitalized or a medical condition is diagnosed after this application is submitted, the Legal Guardian is responsible for notifying Partnering for Preventions' office of the hospitalization or diagnosis.*

Physician's Name _____ Address _____

Office Phone ( ) _____ Physician's Clinic/Hospital Affiliation _____

If you answer "yes" to any of the following, please explain fully, or your application will be returned to you.
Does the participant have any known allergies, including allergies to medications? ☐ Yes ☐ No *If yes, describe the allergy & the reaction:

When was your child's last tetanus shot? ____/_____/_____ Is your child up to date on their school shots? _____

Does the participant have: ☐ diabetes – If yes: Insulin: Type _____ Dosage_____ When Taken _____

☐ epilepsy ☐ fainting ☐ dizziness ☐ blackouts ☐ asthma ☐ heart disease ☐ high blood pressure

☐ sickle cell ☐ anemia ☐depression ☐ any respiratory problems

☐ any other condition for which you are currently under medical care. Describe:

Are you taking any medications at the present time? ☐ yes ☐ No

Medication_____ Dosage _____ When Taken _____ Reason Taken _____

Medication_____ Dosage _____ When Taken _____ Reason Taken _____

Medication_____ Dosage _____ When Taken _____ Reason Taken _____

*Partnering for Prevention may not be capable of altering the nature of its program so as to accommodate certain medical or mental conditions. Some programs may be physically and emotionally challenging, and certain conditions may interfere with legitimate safety requirements. Decisions will be made on a case by case basis by a team of qualified reviewers.

Understanding/Release of Liability/Publicity Authorization – McHenry County Operation Snowball/Snowflake are PREVENTION programs. These programs are designed to keep kids healthy, and does NOT provide therapy or counseling. Participants should not be in need of substance abuse treatment and should be emotionally healthy. For the consideration of participation in these Partnering for Prevention program(s), I hereby release and hold harmless Partnering for Prevention, their members and/or managers, employees, volunteers or agents, and any medical treatment personnel selected, from any and all liability or damages including accidental injury or illness, which may result from the participant's attendance or transportation to/from or during any Partnering for Prevention programs.

I give permission for the applicant to participate in an anonymous survey that measures attitudes, behavior and use of alcohol, tobacco and other drugs, in addition to other prevention related topics. I further give permission for the participant to be photographed/videotaped during attendance at any Partnering for Prevention programs, and for the photographs/videos to be used for promotional purposes.

Authorization by Legal Guardian:

This consent form will be valid and used for all programs my child attends in the year 2016. I agree to notify Partnering for Prevention if anything changes. In addition, participants are required to be signed in and out of program events by an adult. Partnering for Prevention understands that high school students may drive and/or come with someone other than an adult. I give permission for my child to sign themselves in and out of program events unless otherwise noted here: _____.

My signature below indicates I have read the information on this form in its entirety and I agree with, accept, and acknowledge all noted provisions, including consent for Medical Treatment.

Signature of the Legal Guardian (required) _____ Date _____

Participant Drug-Free Agreement:

By signing this agreement, I commit to a healthy lifestyle where I do not use legal drugs illegally nor do I use any illicit drugs. I also agree that during my involvement and participation in Partnering for Prevention programs, I will refrain from using all drugs, both legal and illegal, including all forms of tobacco, with the exception of prescription medications that must be reported on this consent form.

Signature of Participant (required) _____ Date _____