



**YOUTH  
LEADERSHIP  
FOUNDATION, INCORPORATED**



**STAFF  
APPLICATION FORM**

*Circle Conference You Are Asked To Attend*

**YOUTH LEADERSHIP CONFERENCE #1**  
Tallahassee, FL  
7 – 10 MAY 2008

**YOUTH LEADERSHIP CONFERENCE #2**  
Florida Tech, Melbourne, FL  
23-26 JULY 2008

PRINT OR TYPE:

Full Name \_\_\_\_\_ Age \_\_\_\_\_ *Circle One*  
Male Female

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Social Security Number \_\_\_\_\_

Email Address/Addresses \_\_\_\_\_

AFFILIATION OR SCHOOL \_\_\_\_\_

Position \_\_\_\_\_

Address of Student's School \_\_\_\_\_

Name/Address of local news media: \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_ Date \_\_\_\_\_

**FOR FOUNDATION USE ONLY.**  
**ACCEPTED BY:**

DATE: \_\_\_\_\_

by: \_\_\_\_\_

**LTC Henry A. Adams**  
**FOUNDATION DIRECTOR/PRESIDENT**

**STUDENT STAFF MEDICAL HISTORY  
AND  
TREATMENT CONSENT FORM**

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

=====

**IN CASE OF EMERGENCY, NOTIFY: (PLEASE PRINT)**

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

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

Phone (Home): (    ) \_\_\_\_\_ (Office): (    ) \_\_\_\_\_ (FAX): (    ) \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

**AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR  
(This form must be signed by parent or guardian if participant is under 18 years old)**

I (we), the undersigned parents(s) {or guardian(s)} of the above named minor, do hereby authorize the Youth Leadership Foundation's Medical Officer, or his nominee, as agent for the undersigned to consent to any X-Ray, Examination, Anesthesia, Medical or Surgical Diagnosis or treatment and hospital care which is deemed advisable by, or which is to be rendered under the general or special supervision of any Physician or Surgeon licensed to practice in the State of Florida.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of the aforesaid agent to care, which the aforementioned Physician, in the exercise of his best judgment may deem advisable. This authorization will be effective from the first through the last day of the Conference, unless sooner revoked in writing and delivered to said agent.

Date: \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_  
(Signature)

-----  
(Printed Name)

Home Phone Number \_\_\_\_\_

**MEDICAL HISTORY**

**FILL IN THE INFORMATION AS COMPLETELY AS POSSIBLE:**

Date of last complete physical examination (month and year) \_\_\_\_\_

Has it ever been necessary to restrict your physical activities for medical reasons? Yes \_\_\_\_\_ No \_\_\_\_\_

If **YES**, please explain in full: \_\_\_\_\_

Are you aware of any current health problems? Yes \_\_\_\_\_ No \_\_\_\_\_ If **YES**, please explain in full: \_\_\_\_\_

Are you now under medical care or regularly taking medications? Yes \_\_\_\_\_ No \_\_\_\_\_ If **YES**, please explain: \_\_\_\_\_

Has there been any significant surgery, injury, illness or change in health status since your last physical examination?

Yes \_\_\_\_\_ No \_\_\_\_\_ If **YES**, please explain: \_\_\_\_\_

Immunization Dates: TETANUS \_\_\_\_\_ DIPHTHERIA \_\_\_\_\_ POLIO \_\_\_\_\_ MUMPS \_\_\_\_\_

MEASLES \_\_\_\_\_ RUBELLA \_\_\_\_\_ PERTUSSIS \_\_\_\_\_

**EMERGENCY MEDICAL INFORMATION**

**If subject to any of the following, check mark and explain in detail:**

\_\_\_\_\_ Allergy to any plant, food, or animal \_\_\_\_\_

\_\_\_\_\_ Allergy to any drug or insect toxin \_\_\_\_\_

\_\_\_\_\_ Any condition requiring regular medication or diet or special care \_\_\_\_\_

**SUBJECT TO:**

\_\_\_\_\_ Asthma, \_\_\_\_\_ Convulsions, \_\_\_\_\_ Heart Trouble, \_\_\_\_\_ Diabetes \_\_\_\_\_ Bleeding Disorders \_\_\_\_\_

\_\_\_\_\_ Other, Explain \_\_\_\_\_

**AUTHORIZATION AND RELEASE FORM**

I (we), the undersigned, being the natural parent(s) and/or the designated legal guardian(s) or custodian(s) of \_\_\_\_\_, a minor, aged \_\_\_\_\_ years, date of birth: \_\_\_\_\_ hereby authorize, connect and contract as follows:

a. Permission is expressly granted for said minor child to attend the Youth Leadership Conference (YLC) to be held at:

*(Circle your choice of conference)*

- Conference #1 - Florida State University, Tallahassee, Florida, during the period 7-10 May 2008
- or
- Conference #2 – Florida Tech, Melbourne, Florida, during the period 23-26 July 2008

Herein after referred to as the conference site, inclusive, including the necessary travel time, under the joint sponsorship of the Military Order of the World Wars (MOWW) and/or its affiliates, hereinafter referred to as MOWW.

b. It is understood that said child was invited to attend the Conference after being selected from among other applicants in a contest conducted and sponsored by the MOWW, who will provide expenses incurred by the child’s attendance, including transportation, tuition, lodging, meals, tours, materials and all Conference activities.

c. In consideration of the payment of the aforementioned expenses, I (we) hereby release, and contact to hold harmless, the MOWW, and any other cosponsors of the YLC, from any and all liability and/or responsibility for the child’s welfare, well-being and control for the entire period of the Conference, including the day of arrival at, and the day of departure from the conference site.

d. By my (our) signature(s) hereto I (we) attest that I (we) fully understand that I (we) waive any and all rights whatsoever and AGREE NOT TO EXERCISE any right to make a claim or litigate against the Sponsoring Organization and/or the MOWW.

Witness my (our) signature (s) this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_.

_____ (Signature)	_____ (Signature)
_____ (Printed Name)	_____ (Printed Name)
Relationship: _____	Relationship: _____
Address: _____	Address: _____
Phone:(Home)(____)_____	(Work)(____)_____
(FAX)(____)_____	

**ACCEPTED** (by Sponsor):

The Military Order of the World Wars, \_\_\_\_\_ Chapter  
or

\_\_\_\_\_ by \_\_\_\_\_  
(Other Sponsoring Organization) (Authenticating Signature)  
Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Phone:(Home):(\_\_\_\_)\_\_\_\_\_ (Work):(\_\_\_\_)\_\_\_\_\_ (FAX):(\_\_\_\_)\_\_\_\_\_