Amercan Legion Boys State Department of Mississippi

Pre-arrival Health Self-Screening Form

STUDENT DETAILS

Participant Name:	
Contact Telephone:	

SIGNS & SYMPTOMS

Beginning May 16, 2021, please complete each line of the symptom columns daily until the self-monitoring period ends on May 30, 2021.

Date	Temperature	Loss of Taste or Smell	Headache	Fatigue	Sore Throat / Runny Nose	Short of Breath	Cough	Vomiting	Diarrhea	Stomach Pain	Unusual Muscle Aches	Comments
		(√)	(√)	(√)	(√)	(√)	(√)	(√)	(√)	(√)	(√)	
May 16												
May 17												
May 18												
May 19												
May 20												
May 21												
May 22												
May 23												
May 24												
May 25												
May 26												
May 27												
May 28												
May 29												
May 30												

Participant Signature and Date:

* ______________________________

Parent/Gaurdian Signature and Date:

* ______________________________

This form **MUST** be turned into our Health Director at check-In on May 30th.

Revised April 20, 2021

The University of Mississippi
Summer Camps, Conferences, and Programs
Medical Informed Consent
and
Covid-19 Acknowledgement and Waiver

PARTICIPANT INFORMATION		
Participant's Name	Date of Birth	
Camp, Conference, or Program Name	Participation Dates	
Home Address	City/State/Zip	
PARTICIPANT'S PARENT OR LEGAL GUARDIAN		
Parent/Legal Guardian's Name	Relationship to Participant	Preferred Phone and Email
Home Address	City/State/Zip	
EMERGENCY CONTACT		
Name (Must Be Different Than Above)	Relationship to Participant	Preferred Phone and Email
Home Address	City/State/Zip	
PARTICIPANT'S MEDICAL INSURANCE		
Insurance Company	Phone #	Group or Policy #
Member or Policy Holder's Name	Member ID #	
PARTICIPANT'S COVID-19 INFORMATION		
PLEASE REVIEW AND COMPLETE COVID-19 SECTION ON PAGE 3		
PARTICIPANT'S ALLERGIES OR MEDICATION(S)		
☐ **This participant has allergies (COMPLETE PAGE 2)**	☐ **This participant takes medication (COMPLETE PAGE 2)**	

CONSENT, WAIVER AND RELEASE OF LIABILITY

I consent to participate in the above Ole Miss Summer Camp, Conference, or Program, identified above ("Summer Program"). I understand and acknowledge there are inherent risks in participating in the Summer Program that can result in losses, damages, injury or death. These risks may include, but are not limited to, bruises, cuts, transmitted illnesses or diseases, strains, sprains, neck/spinal injuries, broken bones, cardiovascular injuries, dehydration, sunburn, concussions or other bodily injuries. I knowingly and voluntarily assume any and all risks associated with in the Summer Program, wherever such participation may occur, including Participant's transit to and/or from the Summer Program.

In consideration my participation in the Summer Program, I knowingly, voluntarily and forever waive, release and discharge Ole Miss from all present and future claims of any type for any harm or loss, including property damage, personal injury, illness or death, that either I may incur. I agree to indemnify, hold harmless and covenant not to sue Ole Miss for any claims, damages, personal injury, illness, death, medical expenses, disability, lost wages, loss of capacity, property damage, court costs, attorney's fees or any other losses or claims of any kind arising out of my involvement with or participation in the Summer Program.

I acknowledge and agree that it is my sole responsibility to consult with a physician or health care provider regarding participation before I engage in any Summer Program activity. I represent and warrant that I am physically and/or mentally able to participate in the Summer Program and no physician or other health care provider has advised me otherwise. I am not are aware of any health condition or impairment that would prohibit or otherwise limit my participation. In the event of an illness or injury, I hereby authorize Ole Miss to either administer or secure any and all medical treatment necessary or appropriate and to arrange transportation for such treatment, if necessary. I understand and agree that I am financially responsible for all medical or other expenses incurred because an illness or injury. I agree to indemnify and hold harmless Ole Miss for any fees imposed by any physician, hospital, ambulance service or other health care provider. I also agree to release, hold harmless, and forever covenant not to sue Ole Miss for any injury arising out of any medical treatment or the administration of medication that I receive.

I HAVE READ AND UNDERSTAND THIS DOCUMENT AND ACKNOWLEDGE THAT IT LIMITS OR EXTINGUISHES CERTAIN LEGAL RIGHTS THAT I MAY HAVE AGAINST OLE MISS. I UNDERSTAND AND AGREE THAT THIS CONSENT, WAIVER, AND RELEASE OF LIABILITY IS BINDING UPON ME, AND MY RESPECTIVE FAMILY MEMBERS, HEIRS, EXECUTORS, ADMINISTRATORS, ASSIGNS, AND ANY OTHER PERSON WHO PURPORTS TO ACT ON OUR BEHALF.

____ Date: ________________________________
Participant Signature

If Participant is under the age of eighteen (18) years of age, Participant's Parent or Legal Guardian must consent and sign:

_____________________________________ _____________________________________ Date: ________________
Parent or Legal Guardian's Name (Please Print) Parent or Legal Guardian's Signature

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PARTICIPANT'S ALLERGIES

(Complete this section of form ONLY if participant has allergies)

☐ To Foods (list)____ Reaction:__________

☐ To Medications (list)____ Reaction: __________

☐ To the environment /Other (Insect Stings, Hay fever, etc. –list) ____________________ Reaction: __________

PARTICIPANT'S MEDICATION(S)

(Complete this section of form ONLY if medications are needed by participant (under the age of 18) during the Summer Program)

Medication(s) needed by a participant may be administered by the Ole Miss Summer Program Staff under the following conditions:
(a) parent/legal guardian must provide written authorization,
(b) parent/legal guardian must provide the medicine in its original labeled pharmacy container for prescription medication or in the manufacturer's container for over-the counter medications along with the participant's name, medicine name, dosage and timing of consumption,
(c) the provided medication must be picked up within one week of the termination of the camp or the medication will be destroyed and,
(d) a personal "epi" pen and/or inhaler may be carried and self-administered by the participant during activities.

Medication Name & Strength:	Dosage:	Times taken each day:	Reason for taking:

PARENT AUTHORIZATION FOR MEDICATION

I give permission for the participant to take the above listed medication(s) as directed on the packaging and give permission for the medication(s) to be administered by Ole Miss Health & Sports Performance staff as needed according to the instructions provided.

Parent or Guardian's Signature____***Date***______________

PARTICIPANT COVID-19
(To be completed by ALL)

1. Have you tested positive for COVID-19? (circle) YES NO
2. If yes, what date?
3. Have you fully recovered from COVID-19?
4. Do you understand that all participants will be asked to self-monitor for symptoms and screened for symptoms to include temperature checks as deemed appropriate by medical staff? (circle) YES NO
5. I understand that while participating in the Summer Program I will immediately report the following symptoms if they occur: cough, shortness of breath, fever, chills, muscle pain, fatigue, headache, sore throat, congestion or runny nose, nausea/vomiting, diarrhea, and new loss of taste or smell *Initial*________

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The novel coronavirus, COVID-19, is a highly infectious, life-threatening disease declared by the World Health Organization to be a global pandemic. COVID-19's highly contagious nature means that contact with others, or contact with surfaces that have been exposed to the virus, can lead to infection. Additionally, individuals who may have been infected with COVID-19 may be asymptomatic for a period of time, or may never become symptomatic at all. Because of its highly contagious and sometimes "hidden" nature, it is currently very difficult to control the spread of COVID- 19 or to determine whether, where, or how a specific individual may have been exposed to the disease.

I understand that in accordance with current Center for Disease Control guidance, it is highly recommended that all persons continue to wear face masks; adhere to social distancing, including, limiting social gatherings to small numbers; and, that getting vaccinated is encourage when it is made available. I agree that if I am exhibiting symptoms or if, to my knowledge, I have been in contact with anyone diagnosed with COVID-19 or is exhibiting symptoms of respiratory illness, loss of taste or smell, a fever of 100.4°F or higher, or signs of a fever within the last 14 days, I will not participate in the Ole Miss Summer Program ("Summer Program").

By signing up to attend the Summer Program, I acknowledge the contagious nature of COVID-19, the fact that it can be difficult to identify in another, and the inherent risks of exposure in a social setting to those who may be infected with COVID-19. I knowingly and voluntarily assume the risk that I may be exposed to or infected with COVID-19 by participating in the Summer Program. I knowingly and voluntarily waive and release UM from all present and future claims of any type for any harm or loss, including economic loss, personal injury, death, or property damage suffered by me and arising out of my participation in the Summer Program. I agree to indemnify, hold harmless, and covenant not to sue UM for any damages, personal injury, death, medical expenses, disability, lost wages, loss of capacity, property damage, court costs, attorney's fees, or any other loss of any kind.

I acknowledge that I have asked for and/or been given any information that I may need to determine the risks associated with participating in the Summer Program, and to make an informed assumption of those risks. **Aware of the foregoing, I am knowingly and voluntarily participating in the Summer Program.**

I HAVE READ AND UNDERSTAND THIS AGREEMENT AND I AM AWARE THAT BY SIGNING THIS AGREEMENT I MAY BE WAIVING CERTAIN LEGAL RIGHTS, INCLUDING THE RIGHT TO SUE. THIS AGREEMENT SHALL BE BINDING UPON ME AND MY HEIRS, LEGAL REPRESENTATIVES, AND ASSIGNS, AND SHALL INURE TO THE BENEFIT OF THE UNIVERSITY AND THEIR SUCCESSORS AND ASSIGNS.

My signature below indicates that I have read and understand the above statements and intend to be bound legally by its terms.

Participant: DATE:

______________________________ ______________________

Signature

IF PARTICIPANT IS UNDER THE AGE OF 18, PARTICIPANT'S PARENT OR LEGAL GUARDIAN:

____

Signature DATE:

______________________________ ______________________

Relationship to Participant

MEDICAL CERTIFICATE

DELEGATE NAME: ______________________________

SSN: ________________

DOCTOR'S NAME: ______________________________

DOCTOR'S ADDRESS: ______________________________

DOCTOR'S PHONE: ______________________________

Please note in the space below any restrictions on physical activities or exercise, and any imperative information which a caregiver would need in the event of a necessary hospital visit:

____

____

Please note in the space below **any/all medication** that the PARTICIPANT is presently receiving, or any special medical condition/drug precautions:

____

____

I CERTIFY THAT THE ABOVE NAMED DELEGATE TO AMERICAN LEGION BOYS STATE IS IN GOOD PHYSICAL CONDITION AND HAS NO CONTAGIOUS OR INFECTIOUS DISEASE OR SYMTOMS OF THE SAME.

Signature of Medical Doctor: ____

Date: ____

BRING THIS FORM WITH YOU TO REGISTRATION

School Counselor and Local American Legion Post Authorization

DELEGATE FULL NAME: ______________________________

COUNSELOR'S NAME: ______________________________

COUNSELOR'S EMAIL ADDRESS: ______________________________

COUNSELOR'S PHONE NUMBER: ______________________________

STUDENT GPA: ______________________________

STUDENT ACT SCORE: ______________________________

SCHOOL COUNSELOR: Please sign and date on the line below certifying that this student will have completed his junior or senior year by the time he attends Boys State on May 30th, 2021.

SIGNITURE:______________________________ DATE:____________________

AMERICAN LEGION POST #: ______________________________

LEGION POST ADDRESS: ______________________________

____

POST ADJUTANT/COMMANDER: ______________________________

LEGION POST PHONE: ______________________________

Please sign and date on the line below certifying that this student has met with you (Post Commander/Adjutant) and that you approve of him attending the 2021 Mississippi American Legion Boys State Program.

SIGNITURE:______________________________ DATE:____________________

BRING THIS FORM WITH YOU TO REGISTRATION

WAIVER OF CLAIM

I/WE, THE UNDERSIGNED PARENTS, SURVIVING PARENT, OR LEGAL

GUARDIAN OF: ____

NAME OF PARTICIPANT

IN CONSIDERATION OF THE BENEFITS TO BE DERIVED BY MY/OUR SON, IN THE EVENT THAT HE IS A DELEGATE OF THE AMERICAN LEGION BOYS STATE TO BE HELD IN OXFORD, MISSISSIPPI, SUNDAY, MAY 30TH, 2021 THROUGH SATURDAY, JUNE 5th, 2021, DO/DOES HEREBY RELEASE AND DISCHARGE THE AMERICAN LEGION, DEPARTMENT OF MISSISSIPPI, AMERICAN LEGION BOYS STATE, THE UNIVERSITY OF MISSISSIPPI, THEIR OFFICERS, AGENTS, INSTRUCTORS, EMPLOYEES, STAFF AND DIRECTORS FROM ANY AND ALL CLAIMS, DEMANDS, DAMAGES, SUITS, ACTIONS, OR CAUSES OF ACTION WHICH I/WE MAY, CAN OR SHALL HAVE BY REASON OF ANY ILLNESS, INJURY OR ACCIDENT INCURRED OR SUFFERED BY SAID SON WHILE TRAVELING TO OR FROM OR DURING ATTENDANCE OR PARTICIPATION IN THE AMERICAN LEGION BOYS STATE PROGRAM FROM THE TIME OF HIS DEPARTURE FROM HOME UNTIL HIS RETURN THEREOF. I/WE ACKNOWLEDGE THAT ALL PICTURES AND VIDEOS TAKEN BY THE MISSISSIPPI BOYS STATE STAFF DURING THE DURATION OF BOYS STATE ARE THE SOLE PROPERTY OF THE AMERICAN LEGION BOYS STATE, INC. AND/OR THE UNIVERSITY OF MISSISSIPPI TO BE DISPLAYED ON THE BOYS STATE WEBSITE, FACEBOOK PAGE, TWITTER ACCOUNT, OTHER SOCIAL MEDIA ACCOUNT AND RECRUITMENT MATERIAL.

Delegate's Medical Insurance Information:
Insured:_____________________________________
Policy Number: _______________________________
Insurance Company: ___________________________
I understand that any injury or illness may be treated by the medical staff at the UNIVERSITY of MISSISSIPPI or by Baptist Memorial Hospital.

Signatures of Parent(s) or Guardian(s):

X ____

Date: ______________________________

NOTE: ALL PERSONS PARTICIPATING IN THE AMERICAN LEGION BOYS STATE PROGRAM ARE PROVIDED EXCESS INSURANCE COVERAGE FOR ADDITIONAL EXPENSES.

BRING THIS FORM WITH YOU TO REGISTRATION