FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

MISSOURI YMCA YOUTH AND GOVERNMENT

2017 CODE OF CONDUCT AGREEMENT FORM

I, _____, hereby declare that I have read and agree to the following sections within Missouri YMCA Youth and Government Code of Conduct:

- Personal Conduct
- Safety
- Fee Payment
- Facilities
- Dress Code
- Transportation
- Media Release
- Discipline Procedures

I also agree that I will meet all deadlines set forth by Missouri YMCA Youth and Government and understand that failing to do so may result in my delegation not being able to participate in the State Convention.

Signing this document is an agreement that binds me to the policies contained within the Code of Conduct. By signing this agreement, I acknowledge all of the contents of this agreement and am bound hereby.

_____
Signature of Adult Advisor

_____
Please Print Name

_____ / _____ / _____
Date

YOUTH AND GOVERNMENT: 2017 MEDICAL FORM - ADULT

Adult Information

First: MI: Last:

DOB: / / Sex: ☐ M ☐ F School / Delegation:

Emergency Contact Information

Name: Relationship:

Daytime Phone: ( ) - Evening Phone: ( ) -

Name: Relationship:

Daytime Phone: ( ) - Evening Phone: ( ) -

Health History *(Check if you have had any of the following)*

Illnesses: ☐ Diabetes ☐ Convulsions ☐ Heart defect/disease ☐ Ear infections ☐ Blood/clotting disorder

Allergies: ☐ Hay fever ☐ Insect stings ☐ Ivy poisoning ☐ Penicillin ☐ Other drugs:

Diseases: ☐ Asthma ☐ Chicken pox ☐ German measles ☐ Measles ☐ Mumps

List injuries and/or operations and dates (use back of form if necessary):

List any prescription medications and special dispensing needs (use back of form if necessary):

Doctors & Health Insurance

Physician: Phone: ( ) -

Dentist: Phone: ( ) -

Do you have medical / health insurance? ☐Yes ☐No

Carrier: Policy/Group #:

This health history is correct, so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted by me. I hereby give permission to the physician selected by the acting director to order X-rays, routine tests and treatment for my health, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the acting director to hospitalize, secure proper treatment for, and to order injection and or anesthesia and or surgery for me as named above on this form. I understand that my insurance will cover this expense, or I will assume responsibility.

_____ _____ / _____ / _____

Signature of Adult Date