DEADLINE JUNE 3, 2024 – 4:00 P.M.

80th CONNECTICUT AMERICAN LEGION BOYS' STATE LEADERSHIP PROGRAM,
UNIVERSITY OF NEW HAVEN, WEST HAVEN, CONNECTICUT
Saturday, June 22 through Thursday, June 27, 2024

APPLICANT INFORMATION

Last Name		First		MI		DOB	
Street Address				City			
State	Zip		Home Phone		Parent cell Phone *required*		
We are looking into using Apps this year for various aspects of our program. Do you have smart phone capability?		YES ☐	NO ☐	Student *required* Cell phone			
Parent e-mail *required*				Student e-mail *required*			
Parent or Guardian							
Address if different Than above							
Name & Address of School							
Are you a citizen of the United States?	YES ☐	NO ☐	If no, you ***MUST*** attach a copy of your Permanent Resident Card				

PARTICIPATION

The High School Oratorical Contest?	YES ☐	NO ☐	If so, where and placement?	
Are you or have you been a Boy Scout?	YES ☐	NO ☐	If yes, rank & leadership positions held?	
The American Legion Baseball Program?	YES ☐	NO ☐	Post Team/Position	
Sons of The American Legion	YES ☐	NO ☐	If yes, Squadron	

Additional Organizations, Activities & leadership positions held:

The American Legion Boys State Leadership Program is devoted to functional citizenship training of the potential leaders in the various communities of our State. Your admission to American Legion Boys' State depends on your school record, your character, and your qualities of leadership. *The use of or possession of firearms, alcohol or drugs will result in instant dismissal*, **and the Boys' State commission reserves the right to inspect all rooms.** I understand the above information and give permission for my picture and/or voice to be used in the promotion of this program in video, in print and on the Internet and agree to abide by all rules and guidelines of the American Legion Boys' State of Connecticut.

MUST BE SIGNED BY ***APPLICANT AND PARENT/ GUARDIAN***

*APPLICANT :*_____

*PARENT OR GUARDIAN:*_____

SCHOOL:
As principal of _____ High School, I certify the above-named student is a member of the Junior Class. I believe that he will be A responsible Citizen of the American Legion Boys' State because of his Character, Leadership, and interest in Government. His average grades are above "C"
Date: _____ X _____

ATTENDANCE

I understand that I must attend all sessions at Boys' State. If I do not attend all sessions, I understand I will not receive a graduation certificate and Boys' State pin, nor will I be allowed to use Boys' State on any reference or resume

*APPLICANT :*_____

POST INFORMATION OR SPONSORING ORGANIZATION

If the information below is not typed it MUST be neatly written and legible

Sponsoring Post		Other Sponsoring Organization	
Post Representative		Contact Phone	

Authorized Representative Signature:_____ Date:_____

BOYS' STATE LEADERSHIP PROGRAM
Medical Waiver and Release Form

INSURANCE INFORMATION

Name of Insured:	Last		First	
^Insurance Company:				
Policy No.		Group No.		
Name of Policy Holder:		Name of Business or Organization:		

^If there is No Insurance, please state "NONE" in the Company name.

MEDICAL INFORMATION – PLEASE ATTACH A RECENT PHYSICAL (WITHIN THE PAST THREE YEARS)

Name of Attendee:	Last:	First:	
Name of Physician:		Phone Number	
Name of Dentist:		Phone Number	

Does the individual have allergies?	YES ☐	NO ☐	If so, what?
Is the individual on a special diet?	YES ☐	NO ☐	Explain:
Is the individual up to date on all vaccinations?	YES ☐	NO ☐	If no, Explain
Is the individual taking any prescription medications?	YES ☐	NO ☐	If yes, Explain:
Does the Individual have any medical issues or complications?	YES ☐	NO ☐	If yes, please explain below:

Please list any medical issues:

CONSENT TO MEDICAL TREATMENT AND HOSPITAL SERVICES

This will certify that we, the undersigned parents/guardians of _____ do in the event that my (our) son/ward becomes a participating member of The American Legion Boys' State to be held in **West Haven, Connecticut, June 22** through **June 27, 2024** (inclusive) hereby consent and grant permission, should the necessity of medical care arise, to the furnishing of medical treatment and hospital services as ordered or recommended by a qualified attending physician, including the administration of an anesthetic, laboratory procedure, medical or surgical treatment, x-ray examination or other hospital services.

MUST BE SIGNED BY ***PARENT/ GUARDIAN***

*PARENT OR GUARDIAN:*_____ *DATE:*_____

WAIVER & INDEMNIFICATION

We, the undersigned parents/guardians of _____for a valuable consideration, waive and agree to be responsible for and to indemnify and save harmless, The American Legion, Department of Connecticut, Inc. and all subsidiary organizations thereof, the Eastern Connecticut State University, the organization known as THE AMERICAN LEGION BOYS' STATE INCORPORATED and all of their agents, representatives, assistants and servants, from any and all claims, damages or causes of action arising out of injuries which may be received by our said son (ward) while at **The University of New Haven, June 22** through **June 27, 2024** or on the way thereto and therefrom.

MUST BE SIGNED BY ***PARENT/ GUARDIAN***

*PARENT OR GUARDIAN:*_____ *DATE:*_____

RELEASE FORM

I, _____, hereby grant permission to **The American Legion Department of Connecticut**, the rights of my image, in video or still, and of the likeness and sound of my voice as recorded on audio or video tape during the 2024 Boys State session without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published, or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Photographic, audio or video recordings may be used for ANY USE which may include but is not limited to:

- Presentations.
- Courses.
- Online/Internet Videos.
- Media.
- News (Press).

By signing this release, I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet or in the public educational setting.

I will be consulted about the use of the photographs or video recording for any purpose other than those listed above.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

This release applies to photographic, audio or video recordings collected as part of the sessions listed on this document only.

By signing this release, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release all claims against any person or organization utilizing this material for educational purposes.

Full Name_____

Street Address/P.O. Box_____

City _____ State _____ Zip Code _____

Phone_____

Email Address_____

Parents Signature _____ Date_____

Authorization for the Administration of Medication by School, Childcare, and Youth Camp Personnel

In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with the child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's Order (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student _____ Date of Birth _____ Today's Date _____

Address of Child/Student _____ Town _____

Medication Name/Generic Name of Drug, _____ Controlled Drug? ☐ YES ☐ NO

Condition for which drug is being administered: _____ Dosage _____

Method /Route _____ Time of Administration _____ Start Date _____ End Date _____

Specific Instructions for Medication Administration _____

Dosage _____ Method/Route _____

Time of Administration _____ If PRN, frequency _____

Medication shall be administered: Start Date: _____ End Date: _____

Relevant Side Effects of Medication _____ ☐ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs _____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone Number ( ) _____

Prescriber's Address _____ Town _____

Prescriber's Signature _____ Date _____

School Nurse Signature (if applicable) _____

Parent! Guardian Authorization:

I request that medication be administered to my child/student as described and directed above

I hereby request that the above ordered medication be administered by school, childcare and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, childcare nurse, or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)

I have administered at least one dose of the medication to my child/student without adverse effects. (For childcare only)

Parent/Guardian Signature _____ Relationship. _____ Date _____

Parent /Guardian's Address _____ Town _____ State ___

Home Phone# ( ) ___ - _____ Work Phone#( ) ___ - _____ Cell Phone#( ) ___ - _____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically diagnosed allergies, **students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a** student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: ☐ YES ☐ NO _____ _____
Signature Date

Parent/Guardian authorization for self-administration: ☐ YES ☐ NO _____
Signature **Date**

School nurse, if applicable, approval for self-administration: ☐ YES ☐ NO _____
Signature **Date**

Today's Date _____ Printed Name of Individual Receiving Written Authorization and Medication _____

Title/Position _____ Signature (in ink) _____

Note: This form is a sample form in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)

EMERGENCY TREATMENT PLAN FOR ALLERGIC REACTIONS AND ACUTE RESPIRATORY DISTRESS AND THE PERMISSION TO ADMINISTER MEDICATIONS BY CAMP PERSONNEL

☐ Food Allergy ☐ Asthma ☐ Bee/Wasp Stings ☐ Other

Patient's Name: _____ DOB: _____

Physician's Name: _____ Phone Number: _____

Specific Allergy: _____

If the patient thinks he/she has been exposed to the above-named allergen:

☐ Observe patient for symptoms of anaphylaxis X 2 hours

☐ Administer Epinephrine before symptoms occur, IM: ☐ EPIPEN Adult ☐ EPIPEN JR

☐ Administer Epinephrine if symptoms occur, IM: ☐ EPIPEN Adult ☐ EPIPEN JR

☐ Administer Benadryl per appropriate age/weight dose

☐ Call 911, transport to ER

If the patient is experiencing respiratory distress (shortness of breath, wheezing, coughing):

☐ Administer _____ PUFFS of _____ INHALER, REPEAT _____

☐ Call 911, transport to ER

Side effects, if any, to be observed: _____

CAMPER IS TO CARRY & MAY SELF-ADMINISTER EPIPEN / INHALER WHILE AT CAMP:

☐ Yes ☐ No

Physician's Stamp:

Physician's Signature: _____ Date: _____

- IREQUEST THAT MEDICATION BE ADMINISTERED TO MY CHILD AS DIRECTED AND DESCRIBED ABOVE BY CAMP PERSONNEL AND GIVE PERMISSION FOR THE EXCHANGE OF INFORMATION BETWEEN THE PRESCRIBER AND CAMP NURSE AS NECESSARY TO ENSURE THE SAFE ADMINISTRATION OF THIS MEDICATION. I UNDERSTAND I MUST SUPPLY THE CAMP WITH THE NECESSARY MEDICATION.
- IF APPROVED BY THE PHYSICIAN ABOVE, I REQUEST AND GIVE MY PERMISSION FOR MY CHILD TO CARRY AND SELF ADMINISTER THE MEDICATION.

Parent/Guardian Signature: _____ Relationship: _____ Date: _____

Parent/Guardian's Address: _____ Town/State: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Rev. December 2018