International Order of the Rainbow for Girls
Nevada Grand Assembly

PARTICIPANT (OVER AGE 18) INFORMATION FORM
2020

This form incorporates by reference the previously completed Code of Conduct for Members, Media Release, Transportation Release within Geographic Area, and Authorization for Medical Treatment

THIS FORM MUST BE COMPLETED ANNUALLY AND UPDATED AS NEEDED

Member (or Participant) Information

Member's Full Name: _____

Consent to Participate

This consent acknowledges my acceptance of the Code of Conduct for Members, Media Release, Transportation Release within the Assembly's geographic area, and Authorization for Medical Treatment.

Additionally, I hereby release Nevada Grand Assembly, the Supreme Officer, all members and volunteers of Nevada Grand Assembly and the International Order of the Rainbow for Girls, all Assemblies of Nevada Grand Assembly, the Masonic Fraternity, and any sponsoring body or affiliates thereof from any and all responsibility, liability or fault which may arise as a result of any exercise of discretion with respect to the provision of travel and/or health care of the Participant which is authorized by this agreement.

Signature of Participant: _____ Date: _____

Media Release

☐ I consent that photos, images and/or voicing that I have posed for and/or appeared in may be used by the International Order of the Rainbow for Girls (IORG), Nevada Grand Assembly, or its assignees, successors, representatives, or designees in whatever way the desire, including print and electronic media. Furthermore, it is acknowledged that such photographs, films, recordings, plates, and tapes are property of IORG and/or Nevada Grand Assembly, and it shall have the right to sell, duplicate, reproduce, and make other uses of such photographs, films, recordings, plates, and tapes as it may desire, free and clear of any claim whatsoever on my part.

☐ I do NOT consent for any media of myself to be used in any publication.

NV IORG (Girls') Newsletter

☐ Parents/Legal Guardian agree that the Participant may receive the electronic NV IORG Newsletter at the email address provided above, Member (Participant) Information.
☐ Parents/Legal Guardian do not agree to allow the Participant to receive the electronic NV IORG Newsletter.

Authorization for Medical Care

I appoint, authorize and direct the Supreme Officer for Nevada Grand Assembly of the International Order of the Rainbow for Girls, or her designee, as an agent to authorize on my behalf, emergency medical or surgical treatment, including hospitalization, in the event I am unable to do so and which, in the opinion of any licensed physician, surgeon, or hospital, is reasonably required or necessary for my treatment or care. Any physician, surgeon, or hospital is authorized to rely upon any authorization for treatment signed by the above designated agent to the same extent as if executed by me personally.

Member's Name _____

I hereby release Nevada Grand Assembly, the Supreme Officer, all members and volunteers of Nevada Grand Assembly and the International Order of the Rainbow for Girls, all Assemblies of Nevada Grand Assembly, the Masonic Fraternity, and any sponsoring body or affiliates thereof from any and all responsibility, liability or fault which may arise as a result of any exercise of discretion with respect to the provision of travel and/or health care of the Participant which is authorized by this agreement.

Additionally, I agree to be fully and solely responsible for payment or reimbursement of any medical charges or expenses incurred on my behalf and further agree to indemnify and hold harmless those released herein from any claim, demand or action which may be initiated, by any 3rd party, individual, organization or entity, against aforementioned parties for the recovery of such medical expenses, including any legal fees or expenses incurred in defending against such claims.

Participant (over the age of 18) Medical Information
(Check all that apply; if box checked, please explain)

I have the following known allergies:
☐ Drug/Medication:
☐ Food:
☐ Insect Stings:
☐ Hay Fever:
☐ Other:

I have the following chronic/recurring illnesses:
☐ Asthma:
☐ Diabetes:
☐ Seizures/Epilepsy:
☐ Heart Condition:
☐ Other:

I have the following physical limitations:

Additionally, I wish to disclose use of the following medications: _____.

Medical Insurance Information
☐ I have medical/health insurance through my Parents/Legal Guardians.
☐ I have my own medical/health insurance with the following medical insurance carrier:

Carrier Name: _____ Carrier Telephone Number: _____

Policy Holder's Name: _____

Group ID: _____ Policy #: _____

Signature of Participant: _____ Date: _____