

**International Order of the Rainbow for Girls
Nevada Grand Assembly**



CONSENT TO PARTICIPATION – EVENTS OUTSIDE ASSEMBLY’S GEOGRAPHIC AREA
A NEW FORM MUST BE COMPLETED FOR EACH OUT-OF-AREA EVENT
OUT OF STATE TRAVEL WILL ALSO REQUIRE A SEPARATE PARTICIPANT INFORMATION FORM

On ___ / ___ / ____, _____ Assembly # ___ will be traveling to _____ to participate in _____. The Assembly will return on ___ / ___ / _____ at approximately _____.

The adult Points of Contact for this event, both of whom will be traveling with the group, are:

_____ and _____.

Participant Information

Full Name: _____ DOB: ___ / ___ / _____

Parents/Legal Guardians - contact Information during the event

Name: _____ Name: _____

Phone: C _____ H _____ Other _____ Phone: C _____ H _____ Other _____

Consent to Participate

As the Parents/Legal Guardians of the above named participant, referred to hereafter as “Participant”, permission is granted to participate in the above referenced event. This consent acknowledges continued acceptance of the Code of Conduct for Participants, Media Release, Transportation Release, and Authorization for Medical Treatment included by reference in the Participant Information Form. It is agreed that the Parents/Legal Guardians are responsible for any costs incurred in the event the Participant must return from the event due to non-compliance with the Code of Conduct.

Signature of Participant: _____ Date: ___ / ___ / _____

Signature of Parent/Legal Guardian: _____ Date: ___ / ___ / _____

Signature of Parent/Legal Guardian: _____ Date: ___ / ___ / _____

Medical Release Update

In addition to the previously signed Participant Information Form, the following update is provided:

Participant has the following known food and medical allergies: _____

Participant will be taking these over the counter and prescribed medications during the event:

Participant has consent to be administered appropriate amounts non-prescription medications (i.e. Tylenol or ibuprofen) with the following exceptions (list only what the Participant MAY NOT be administered):

The Participant has active medical insurance coverage with the following medical insurance carrier:

Carrier Name: _____ Carrier Phone Number: (_____) _____

Group ID: _____ Policy #: _____