



2020 YMCA Global Program  
Health & Safety Packet

Please bring to your Trip Group Leader

OR

Mail to:

**Attn. Natasha Gupa**  
YMCA of Greater Seattle  
Association Office  
909 Fourth Avenue  
Seattle, WA 98104  
P 206.382.4969

**Email:** [Internationalprograms@seattleyymca.org](mailto:Internationalprograms@seattleyymca.org)

**Complete Packet Due by: April 1st, 2020**

|                   |  |
|-------------------|--|
| Participant Name: |  |
| Street Address:   |  |
| City/State/Zip:   |  |
| Home Phone:       |  |

**YMCA of Greater Seattle  
2020 Assumption of Risk and  
Release from Liability**

Participant Name: \_\_\_\_\_

The YMCA of Greater Seattle is proud to provide international education and service programs. Traveling, by its very nature, carries a significant risk to one's safety. Although we do not want to diminish your enthusiasm for the experience, we do want you to know in advance what to expect, and what some of the potential risks are by participating in this activity.

**AWARENESS OF RISKS:** The participant and the parent or guardian ("we") understand YMCA staff members will be leading the trip, but they are not able to directly supervise or be with participants at all times. We understand participants must follow safety instructions, respect local laws and customs, and refrain from behavior that is harmful to others or themselves. We understand that participants will be exposed to certain risks and hazards inherent to traveling abroad, including transportation by plane, bus, taxi and other methods common to other cultures. Unusual activities may include light manual labor in service projects, attending the Kobe YMCA summer camp and living (sleeping and eating) in host homes in Kobe. Risks include, but are not limited to, severe illness, getting lost, accidents while being transported, lost luggage, falls, robbery, assault, and severe weather conditions. Consequences of such accidents or events could be strained muscles, broken bones, abrasions, mental strain and anguish, concussions, spinal injury and even permanent disabilities or death. In consideration for being able to participate, we agree to accept these and other unforeseen risks.

**MEMBER HEALTH:** We represent that the program participant is in physically sound condition, and understand that participation in travel abroad carries a potential risk of injury or illness. We agree to inform the staff person in charge about any special health conditions or medical needs which may be affected by this activity. We further understand that the YMCA of Greater Seattle assumes no responsibility for any such injury or illness.

**MEMBER CONDUCT:** We have signed the Code of Contract, and agree to abide by the YMCA code of conduct and all rules and regulations of the trip, and we understand that failure to act in accordance with the rules may result in early removal from the trip and return home. We agree to pay all extra expenses involved in early removal.

**PROPERTY LOSS:** We understand that the YMCA is not responsible for personal property lost, damaged or stolen while using YMCA facilities or participating in YMCA programs. This includes lost luggage during travel.

**PHOTOGRAPH PERMISSION:** We hereby give permission for the YMCA to use, without limitation or obligation, photographs, film footage or tape recordings which may include participant's image or voice for purposes of promoting or interpreting YMCA programs.

**INSURANCE:** We understand it is the responsibility of every individual, his or her parent or legal guardian, to provide for his or her own accident and health coverage while participating in any YMCA activity. The YMCA does not provide any accident or health coverage for its participants. We understand it is our responsibility to provide for health and accident coverage while traveling overseas on this trip.

**MEDICAL TREATMENT:** We hereby give permission for the participant to be given cardiopulmonary resuscitation (CPR) and first aid treatment by a qualified staff member of the YMCA. We also give permission to be transported by ambulance or aid car to an emergency center for treatment. In the event that the participant cannot respond, we further consent to the medical, surgical and hospital care treatment and procedures (including, but not limited to, administration of necessary anesthetics, tests, x-ray examinations, transfusions, injections and drugs) to be performed by a physician or hospital selected by the YMCA staff when deemed immediately necessary or advisable by the physician to safeguard the participant's health.

We accept and understand the possibility of risks associated with this program.

**RELEASE FROM LIABILITY:** By signing below, we agree to release the YMCA of Greater Seattle, its directors, officers, employees, volunteers and agents from and against any and all negligence, claims, damages, losses and expenses, including attorney fees, arising from any occurrence causing damage or injury to the participant relating to the Teen Leadership Trip to Japan. If any portions of the waiver are held to be invalid, we agree that the remaining terms shall continue to be in full legal force and effect.

Participant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**2020 YMCA of Greater Seattle  
Code of Conduct**

Participant Name: \_\_\_\_\_

Since you will be traveling with a group, you will find yourself with opportunities and challenges you may not experience in your everyday life. This code of conduct was developed to ensure the best possible experience for everyone - you, your fellow teens, your leaders and the host YMCA.

It is important that each potential group member read this contract carefully. Can you accept and live by the rules which are listed below? Read and review the contract with your parents/guardians, and if you agree to it, sign it and get their signature as well. The contract is a requirement for the program; you cannot participate unless you accept its code of conduct.

1. Illegal substances -- All alcohol, illegal drugs, and tobacco products are prohibited on the trip. Anyone using prescription medicine must notify the trip leaders before departure.
2. Inappropriate Behavior---Restrain from sexual activity of any kind, fighting, and harmful or disorderly behavior.
3. Rights of others -- Participants must respect the rights and personal property of other people at all times.
4. Group participation -- It is expected that anyone applying as a group member will travel with the group the entire trip. Attendance at all events and activities is mandatory. It is expected that participants will participate fully, show a willingness to learn, and cooperate with the group leader and group to ensure the best experience possible for all participants.
5. Leaders' rules -- Participants must agree to follow the rules of conduct set by the leaders and by the parents in your host family.
6. Ambassador for the USA -- Participants will do their best to be good ambassadors for their families, their YMCA and for the USA.
7. Respecting other cultures -- Participants will show respect all times towards their hosts, their culture and their country. Participants will obey the laws of the host country. Another YMCA and its families have invited the group into their world. Participants must make every effort to appreciate the difference environments, cultures and people of the host country.

**I have read and understand the above rules and policies. I agree to abide fully by the program's rules of conduct. I understand that I will be sent home at my parent's expense, if I fail to comply with this agreement.**

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**YMCA of Greater Seattle  
2020 Insurance & Treatment Release**

Participant Name: \_\_\_\_\_

**This form is to be completed by parents/guardians of minors and is gathered to assist us in identifying appropriate care for your child. Please print clearly.**

**Lives with Parent/Guardian Information:**

Parent/Guardian 1: \_\_\_\_\_ Relationship: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ Company: \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Parent/Guardian 2: \_\_\_\_\_ Relationship: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ Company: \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Which of the above numbers will you be at while your child is in the program?  Home  Work  Cell

If none of these, please provide us with an alternative way of reaching you: \_\_\_\_\_

If you are not available in an emergency, whom should we notify? \_\_\_\_\_

Relationship to participant? \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Alternate phone numbers: \_\_\_\_\_

**Insurance & Physician Information:**

It is the responsibility of every participant's parent or legal guardian to provide for the participant's own accident and health insurance coverage while participating in YMCA activities. The YMCA of Greater Seattle does not provide any accident or health coverage for its participants. Please attach a copy of insurance card.

Is the participant covered by family medical/hospital insurance?  Yes  No

If yes, indicate insurance carrier and plan name: \_\_\_\_\_

Carrier address (including city, state, zip code): \_\_\_\_\_

Name of insured: \_\_\_\_\_ Relationship to participant: \_\_\_\_\_

Insurance ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of family physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name of family dentist: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**Parent/Legal Guardian Authorization:**

This health history is correct so far as I know, and my child has permission to engage in all prescribed program activities as noted by me and/or the examining physician. I hereby give permission to the physician selected by the program director to order x-rays, routine tests and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the program director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above. This form may be photocopied for use out of the program.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Medications**

Please list **ALL** medications (*including over-the-counter or nonprescription drugs*) taken routinely. Keep meds in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of dispensation. **No loose pills/vitamins in zip lock bags are allowed.** Be sure to bring enough medication to last the entire time in the program.

This person takes medications as follows: **(please specify if this is for a life-threatening condition and print clearly)**

B=Breakfast    L=Lunch    D=Dinner    BT=Bedtime    PRN=As Needed

Med #1: \_\_\_\_\_ Dosage: \_\_\_\_\_ Circle specific times taken: B L D BT PRN

Reason for taking: \_\_\_\_\_

Med #2: \_\_\_\_\_ Dosage: \_\_\_\_\_ Circle specific times taken: B L D BT PRN

Reason for taking: \_\_\_\_\_

Med #3: \_\_\_\_\_ Dosage: \_\_\_\_\_ Circle specific times taken: B L D BT PRN

Reason for taking: \_\_\_\_\_

Med #4: \_\_\_\_\_ Dosage: \_\_\_\_\_ Circle specific times taken: B L D BT PRN

Reason for taking: \_\_\_\_\_

*Attach additional pages for more medications*

This person takes NO medications on a routine basis.

I give my permission for YMCA staff to dispense to my child the following over-the-counter medications for common ailments:

|                      |                              |                             |                          |                              |                             |
|----------------------|------------------------------|-----------------------------|--------------------------|------------------------------|-----------------------------|
| Topical Ointments    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sunblock                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cough Drops/Lozenges | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Benadryl (antihistamine) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tylenol              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Claritin (Loratadine)    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ibuprofen            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other (specify: _____)   |                              |                             |

For females: Has this person menstruated? \_\_\_\_\_

If not, has she been told about it?  Yes  No      If so, is her menstrual history normal?  Yes  No

Special considerations: \_\_\_\_\_

This person requires an **inhaler, nebulizer or other medical device(s)** and will bring it/them:

Will check it/them in with other medications.       Must carry it/them with him/her at all times.

Description of device(s) and instructions for operation: (attach additional pages if necessary)

Does participant carry an **epi-pen**?  Yes  No

Will check it/them in with other medications.       Must carry it/them with him/her at all times.

**YMCA of Greater Seattle  
2020 Health History**

Participant Name: \_\_\_\_\_

| Has/does the participant:                              | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Had any recent injury, illness, infectious disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have a chronic or recurring illness/condition?      | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever had surgery?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have frequent headaches?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Ever had a head injury?                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Wear glasses, contacts, or protective eye wear?     | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ever had frequent ear infections?                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Ever passed out during or after exercise?           | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Ever had seizures?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Ever had high blood pressure?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Ever been diagnosed with a heart murmur?           | <input type="checkbox"/> | <input type="checkbox"/> |

| Has/does the participant:                          | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 12. Ever had back problems?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Ever had problems with joints (knees, ankles)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have an orthodontic appliance?                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have any skin problems (itching, rash, etc)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have diabetes?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Had mononucleosis in the past 12 months?       | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Had problems with diarrhea or constipation?    | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have problems with sleepwalking?               | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. If female, have an abnormal menstrual history? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have a history of bed-wetting?                 | <input type="checkbox"/> | <input type="checkbox"/> |

Please explain any "yes" answers, noting the number of the question: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

| Has/does the participant suffer from:  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. ADHD? <input type="checkbox"/> Severe <input type="checkbox"/> Moderate       | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Bipolar?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Depression? <input type="checkbox"/> Severe <input type="checkbox"/> Moderate | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Obsessive/compulsive behavior?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Aggression towards others?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Aggression towards self?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Reactive attachments?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Anxiety disorders?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Conduct disorders?  | <input type="checkbox"/> | <input type="checkbox"/> |

|  |                          |                          |
|--|--------------------------|--------------------------|
| 10. Abuse issues?<br><input type="checkbox"/> Physical <input type="checkbox"/> Emotional <input type="checkbox"/> Sexual?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Running away?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Eating disorders?<br><input type="checkbox"/> Anorexia? <input type="checkbox"/> Bulimia <input type="checkbox"/> Overeating   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Dietary restrictions? *<br><input type="checkbox"/> Glucose intolerant <input type="checkbox"/> Lactose intolerant   | <input type="checkbox"/> | <input type="checkbox"/> |
| *We are unable to provide a substitute diet for these conditions. If you wish to provide a supplemental diet for your lactose or glucose intolerant child, please contact Jennifer Parker at (206) 382-5086. |                          |                          |

Please explain any "yes" answers, noting the number of the question: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

RESTRICTIONS: Explain any restrictions to activity (e.g., what cannot be done, what adaptations or limitations are necessary):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Participant Name: \_\_\_\_\_

**Allergies**

|  |  |
|--|--|
| Medication allergies (list):<br>_____<br>_____<br>_____  | Describe reaction and management of the reaction:<br>_____<br>_____<br>_____ |
| Food allergies (list):<br>_____<br>_____<br>_____  | _____<br>_____<br>_____  |
| Other allergies (list) -include insect stings, hay fever, asthma, animal dander, etc.:<br>_____<br>_____ | _____<br>_____   |

Which of the following has the participant had?

- |   |  |
|---|--|
| <input type="checkbox"/> Measles        | <input type="checkbox"/> Varicella Zoster (shingles) |
| <input type="checkbox"/> Chicken Pox    | <input type="checkbox"/> Mumps                       |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Hepatitis                   |

Please provide the last immunization date for the following:

| Date | Vaccine                  | Date | Vaccine                 |
|------|--------------------------|------|-------------------------|
|      | DTP                      |      | TD (tetanus/diphtheria) |
|      | Polio                    |      | Measles or Rubella      |
|      | Tetanus                  |      | TB Mantoux Test         |
|      | Haemophilus Influenzae B |      |                         |

Participant is exempt from immunizations for medical, religious or personal reasons.

Please explain: \_\_\_\_\_

Has participant been in counseling with a psychiatrist, psychologist, therapist or other counselor within the past two years?  Yes  No

Is the participant currently in counseling?  Yes  No

Reason for counseling:  Academic  Family issues  Depression  Substance abuse  Suicide  
 Other \_\_\_\_\_

If currently in counseling, please make arrangements with counselor for Release of Information should it become necessary for us to contact him/her. Release of information arranged?  Yes  No

Name of counselor: \_\_\_\_\_ Phone: \_\_\_\_\_

Are there special family considerations which may affect your child's participation in this program?  
\_\_\_\_\_

Has your child been dealing with any issues of concern during the past school year?  
\_\_\_\_\_  
\_\_\_\_\_

Participant Name: \_\_\_\_\_

What suggestions do you have for approaching your child, in relation to inappropriate behavior?

---

---

Use this space to provide any additional information about the participant's behavior and physical, emotional or mental health about which we should be aware:

---

---

---

---

---



Participant Name: \_\_\_\_\_

**Authorized Pick-Up Persons**

**I give my permission for YMCA staff to release my son/daughter to any of the person(s) listed below. I also understand that I, or the authorized person, will present a photo ID to the YMCA staff responsible for checking out participants on the final day of the program.**

**Please print:**

Parent/Legal Guardian: \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_

Pick-up person #3: \_\_\_\_\_ Relationship: \_\_\_\_\_

Pick-up person #4: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_  
**Custodial Parent/Legal Guardian Signature**

\_\_\_\_\_  
**Date**