

NATIONAL FEDERATION

FOR JUST COMMUNITIES™

of Western New York, Inc.

Application for the “Community Build: Institute for Inclusion”

High School Retreat – November 20-22, 2015

STUDENT’S NAME _____
(Last Name) (First Name) (M.I.)

PARENT/GUARDIAN NAME(S) _____

MAILING ADDRESS _____

CITY / TOWN _____ ZIP CODE: _____ E-MAIL ADDRESS _____

HOME PHONE # _____ CELL. # _____

SCHOOL _____

RECOMMENDATION MADE BY _____ TITLE _____

RELATIONSHIP TO APPLICANT (CIRCLE): TEACHER COUNSELOR OTHER _____

DELEGATE IS RECOMMENDED BECAUSE: (please use additional paper if necessary) _____

Delegate Demographics: please check all that apply: (Please note: This information is for statistical purposes only – NO STUDENT(S) WILL BE DISQUALIFIED BECAUSE OF THEIR ANSWERS.)

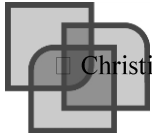
Gender of Delegate: _____ **Age** _____ **Grade** _____ **Date of Birth** ___/___/___

Race / Ethnicity of Delegate:

- African/ African American/Black
- Asian//Pacific Islander
- Bi/Multi-Racial
- Caucasian
- Indian/Central Asian
- Latino/Hispanic
- Middle Eastern
- Native American
- Other, please list:

Religion/Faith Tradition of Delegate:

- Atheist
- Baha’i
- Buddhist
- Christian/Catholic



Christian/Non-Denominational Christian/Protestant Hindu Islam/Muslim

Jewish Native American/Traditional

Other _____

Community Build: Institute for Inclusion / Delegate Application

Please complete the following requested information (print or type)

Where were you born? (City/Town/State/Country)

What Languages do you speak? _____

List involvement in school, work or community activities:

What current or past leadership roles have you held? _____

Please list at least one goal that you will work towards while at commUnity build:

Please list two things about yourself that people would be surprised to know:

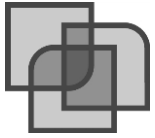
**NOTE: THERE IS NO COST INVOLVED TO THE DELEGATES ATTENDING
the “Community Build: Institute for Inclusion”**

**Delegates will be required to bring some items for their comfort during the program.
A “What to Bring List” will be sent to those selected to participate.**

SIGNATURE OF DELEGATE: _____ **DATE** ___/___/___

Completed applications are due by Tuesday, November 10, 2015.

They can be mailed/faxed to:



The NFJC of WNY, Inc.
360 Delaware Ave, Suite 106
Buffalo, New York 14202
716.852.0046 – fax



Community Build: Institute for Inclusion

PROGRAM PARTICIPATION CONSENT FORM

INSTRUCTIONS: Please read carefully and sign. If the applicant is under 18 years of age, both the applicant and their parent/guardian must sign. If either signature is missing, the application will not be processed.

I understand that the Community Build: Institute for Inclusion is an intensive human relations program that deals with mature subject matters. I understand that discussion topics may include values clarification, self-reflection, stereotypes and prejudice, interpersonal communication, racial identity, racism, sexism, heterosexism, classism, family issues, institutional and personal power, and other issues of oppression.

I understand that participants and staff often find it to be an emotional experience. Throughout the weekend participants may experience confusion, anger, joy, sadness, frustration, hope and other emotions related to the challenging issues of bigotry as they learn about the impact discrimination has on the lives of individuals. Participants will be asked to complete a series of written evaluations during and after the program. I hereby grant permission for my child to complete evaluation questionnaires.

I assure you that my child has, and I have, no known mental or emotional disorders or sensitivities that would interfere with my/my child's participation, and that I am/my child is capable of handling the subject matter and emotional nature of this program.

I understand that although NFJC has taken precautions to provide proper organization, supervision, instruction, and equipment for each activity, it is impossible for NFJC to guarantee absolute safety. I also understand that each participant shares the responsibility for safety during all activities, and I assume that responsibility for myself/for my child. I waive any claim that may arise against the Board of Directors of the NFJC of WNY, Inc. and/or its employees, agents, volunteers or lessors, including those claims that may arise from the negligence of NFJC of WNY, Inc.; its Board of Directors, and/or its employees, agents, lessors or volunteers.

For parents/guardians:

If the President or Program Director of the NFJC must send me/my child home for any reason, I agree to pick up my child within four hours of the President's or Program Director's call. I understand that I may be called at any time of the night or day to arrange for my child's transportation home and that I will be responsible for all costs associated with such transportation.

If my/my child's medical information should change prior to the Institute, I will notify NFJC of any new conditions, medications, limitations, etc.

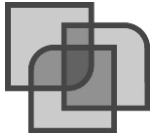
I have read and understand all the registration documents required for my/my child's participation in this NFJC program.

Participant's Name (print): _____

Participant's Signature: _____ Date: _____

Parent/Guardian's Name (print): _____

Parent/Guardian's Signature: _____ Date: _____



PROGRAM PARTICIPATION CONSENT FORM [CONTINUED]

Personal Information

Please respond to the following:

I do grant permission for my/my child’s name, phone number and additional contact information to be distributed to other participants on the program roster.

I do not grant permission for my/my child’s name, phone number and additional contract information to be distributed to other participants on the Institute roster.

Participant’s Initials: _____ Parent/Guardian’s Initials: _____

Photo Release

I am the parent or legal guardian of _____ (child’s name), who will be participating in the Community Build: Institute for Inclusion and/or follow-up activities, sponsored by The National Federation for Just Communities of Western New York (NFJC).

I understand that my child, alone or with other participants and/or NFJC Staff, volunteers or representatives, may be interviewed, may provide written or oral statements, and/or may be photographed recorded on film, audio tape, videocassette, or other visual and sound, computerized, telephonic, voice-mail or tape media (“photographs and/or sound/image recordings”) by NFJC and/or other approved by NFJC.

I hereby consent to the foregoing and grant permission, without reservation, to NFJC and/or those approved by NFJC to generate, prepare, advertise, describe and/or publicize NFJC and its work, good will, public education and/or fundraising activities, disseminate, otherwise use and comment upon the photographs and/or sound/image recordings as they may determine, without review by me or my child and without financial or other obligation of any nature to me or my child.

I consent that my child may be identified by name, age and place of residence or otherwise, as NFJC and/or those approved by NFJC may determine.

I release NFJC, its Board Members, volunteers, agents, employees, licensees and assigns from all claims that I or my child may have, or might have, for any cause of action arising out of the taking and/or use of the photographs and/or sound/image recordings as set forth herein.

This consent and release shall continue in effect, without a limitation of time.

I do consent and agree to the photo release terms mentioned above.

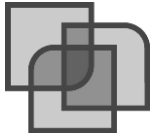
I do not consent or agree to any of the photo release terms mentioned above.

Parent/Guardian’s Name (print): _____

Parent/Guardian’s Signature: _____

Relationship (if signing for a minor): _____ Date: __/__/__

Signature of Child: _____



Community Build: Institute for Inclusion

Health and Medical Release Forms

The information on this form is not part of the participant acceptance process. This Information is gathered to assist in identifying appropriate care for the participant. **This form must be completed by the parent(s)/guardian of minors and by any adult volunteer or program applicant/participant.** Keep a copy of the completed form for your records. Any changes to this form should be provided to the Program Director prior to the participant's involvement in the residential program. Please make sure you provide detailed and accurate information so that the staff members are aware of your/your child's need(s).

Participant's Name (Last, First, M.I.): _____

Home Address: _____

Birth Date: _____ Age: _____

Parent/Guardian's Name: _____

Parent/Guardian's Daytime Phone: _____ Evening Phone: _____

Home Language: _____

Please list TWO other Emergency Contacts:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Does the applicant have physical limitation(s) that will restrict participation in activities? Yes No

If yes, please explain: _____

Has the participant been injured and/or needed medical care in the last year? Yes No

If yes, please explain: _____

Is the participant currently undergoing professional counseling or therapy? Yes No

If yes, please explain: _____

Allergies

Allergies to Medication? Yes No

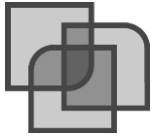
If Yes, please list: _____

Allergies to food? Yes No

If Yes, please list: _____

Other allergies? Yes No

If Yes, please list: _____



Community Build: Institute for Inclusion

Health and Medical Release Forms Continued

Medications

Please list all medications, including OTC's or nonprescription, taken routinely. Bring enough medication to last the entire duration of the program. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the medication's name, the dosage, and the frequency taken.

Does the participant take medications on a routine basis? Yes No

Will the participant be taking any prescription medications during the program? Yes No

If yes provide the following information: (attach additional pages as needed)

Med #1: _____ Dosage: _____

Specific times taken each day: _____

Reason taken: _____

Medications taken during school year NOT taken during summer: _____

Does the participant have any of the following medical conditions? (check any/all that apply)

- Obsessive Compulsive Disorder Asthma Neurological Disorder
- Heart Problem Social Anxiety Skin Infection
- Pulmonary Disorder Otitis Media Diabetes
- Depression Hepatitis ADD/ADHD
- Allergies HIV Positive Epilepsy/Seizures
- Muscular-Skeletal Disorder Other conditions/issues the staff should be aware of? (list)

Parent/Guardian Authorization

This Health History is correct and complete as far as I know, and the person herein described has permission to engage in program activities, except as noted.

Signature: _____

Date: _____

Dietary Restrictions

Please remember that this event is not catered. Food cannot be prepared to order and the facility(ies) may not have a kosher kitchen. Please check all restrictions that apply to the participant.

- Does not eat meat Does not eat pork Does not eat eggs
- Does not eat poultry Does not eat seafood Does not eat dairy products
- Other: _____

Participant's Agreement to Abide by Restrictions

I, _____, understand and agree to abide by the restrictions placed on my activities and diet, as listed above, during this program.

Signature: _____

Date: _____