



**NEW JERSEY ASSOCIATION OF STUDENT COUNCILS**  
c/o Palmyra H.S. – 5<sup>th</sup> & Delaware Ave. – Palmyra, NJ 08065 – (609) 367-4176  
**LTC 2009 Delegate Registration Form – Part 1**

**Please return ALL 3 PARTS of this form (and Part 4 if necessary) completed with ALL NECESSARY SIGNATURES to the NJASC Southern Office by JUNE 30, 2009!**

PLEASE CHECK:                      SESSION 1 (July 15-18)                       SESSION 2 (July 19-22)

*Please type or print your personal information in the space provided:*

NAME: \_\_\_\_\_ GRADE IN SEPTEMBER: \_\_\_\_\_  
SEX:    MALE     FEMALE     AGE: \_\_\_\_\_ BIRTHDAY: \_\_\_\_\_  
ADDRESS    Street: \_\_\_\_\_  
                  City/Zip: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_  
CELL PHONE: \_\_\_\_\_  
E-MAIL: \_\_\_\_\_  
SCHOOL NAME: \_\_\_\_\_ ADVISOR PHONE: \_\_\_\_\_

Do you have any special housing or dietary needs?                      YES                       NO

If YES, please explain: \_\_\_\_\_

*Please neatly print your answer to each of the following questions:*

1. What leadership positions have you held?
2. Do you have any recent experiences in music or dramatics?
3. What is your interest or involvement in athletics?
4. What are your hobbies or other interests?
5. What is your reason for attending LTC?
6. What school or community service projects have you been involved with?
7. Please feel free to give any additional information about yourself on the **back of this page**.



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**LTC 2009 Delegate Registration Form – Part 2**

PLEASE CHECK:

SESSION 1 (July 15-18)

SESSION 2 (July 19-22)

**MEDICAL PERMISSION FORM**

*Absolutely NO student will be allowed to register without submitting this information!*

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_  
                    Last                      First                      Middle

HOME PHONE: \_\_\_\_\_ PARENT NAME(S): \_\_\_\_\_

PARENT CONTACT PHONE NUMBERS: \_\_\_\_\_

*ON THE BACK OF THIS FORM PLEASE PRINT the name, address and phone number of a person (other than parents) to be contacted in case of emergency.*

*(If you require more space for any section of this form, use the back or attach a separate sheet.)*

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Is the delegate now or within the last 2 months been under the care of a physician?  
If so, why? \_\_\_\_\_

Does the delegate take any MEDICATION? If so, please list below:  
\_\_\_\_\_

Date of last TETANUS SHOT (please check with physician): \_\_\_\_\_

Should the delegate be restricted from any type of recreational activity? YES  NO

If you answered YES above, please explain:  
\_\_\_\_\_

Is there any other pertinent information that we should know? If so, please explain:  
\_\_\_\_\_

Is there any other MEDICINE required by the delegate while at LTC? If so, please explain:  
\_\_\_\_\_

***\*ALL MEDICATION (INCLUDING OVER THE COUNTER MEDICATIONS) MUST BE HELD AND ADMINISTERED BY THE NURSE. MEDICATION MUST BE IN A LABELED CONTAINER WITH DELEGATE'S NAME, NAME OF MEDICATION, AND HOW IT IS TO BE TAKEN.***

Insurance Company Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

*"I hereby give my approval for emergency medical treatment if deemed necessary. The delegate IS  IS NOT  permitted to take over the counter medication\*."*

PARENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



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**LTC 2009 Delegate Registration Form – Part 3**

PLEASE CHECK:                      SESSION 1 (July 15-18)                       SESSION 2 (July 19-22)

*Please type or print your personal information in each of the following fields:*

NAME: \_\_\_\_\_ GRADE IN SEPTEMBER: \_\_\_\_\_  
SEX:    MALE     FEMALE     AGE: \_\_\_\_\_ BIRTHDAY: \_\_\_\_\_  
ADDRESS Street: \_\_\_\_\_  
                  City/Zip: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_  
CELL PHONE: \_\_\_\_\_  
E-MAIL: \_\_\_\_\_  
SCHOOL NAME: \_\_\_\_\_ ADVISOR PHONE: \_\_\_\_\_

*The above named student is an official delegate from our school to the NJASC Leadership Training Conference. He/she is recommended as a person of good character and has proven him/her self to be a worthy school citizen.*

\_\_\_\_\_  
*Signature of Principal*

\_\_\_\_\_  
*Signature of Advisor*

**THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS AND THOSE OF THE STUDENT DELEGATE.**  
**PLEASE READ CAREFULLY BEFORE SIGNING!**

Dear Parent/Guardian:

The student delegate (“delegate”) listed above has been selected to participate in the 2009 Leadership Training Conference (“LTC”) sponsored by The New Jersey Association of Student Councils (NJASC). **By signing below, I agree that the delegate listed above has my consent to participate in LTC and that in exchange for, and in consideration of, the benefits of participating in LTC:**

I give permission to the NJASC to use the delegate’s picture, likeness, and/or name in marketing and promotional materials for the NJSAC and LTC, including, but not limited to, videos, presentations, newsletters, press releases, and the NJASC website located at [www.njasc.org](http://www.njasc.org).

In the event of an emergency, I grant the staff of LTC permission to arrange for and authorize emergency medical care for the delegate, including transportation by an LTC staff member, and agree to pay in full for any expenses related to such medical care.

I agree that the delegate, and I as his/her parent or legal guardian, will not bring suit or make any claim against LTC, the NJASC, or their directors, officers, staff, volunteers, representatives, agents, and employees for personal injury, property damage, or any other harm related to his/her participation in LTC.

I agree to defend, indemnify, and hold harmless LTC, the NJASC, and their directors, officers, staff, volunteers, representatives, agents, and employees for any and all liability—including, but not limited to claims for personal injury, property damage, or any other harm—brought by a third party which may arise out of the delegate’s conduct or activities at LTC.





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**LTC 2009 Delegate Registration Form – Part 4**

PLEASE CHECK:                      SESSION 1 (July 15-18)                       SESSION 2 (July 19-22)

**MEDICATION ADMINISTRATION FORM**

***If your child will be taking any kind of medication while at LTC, this form MUST be completed and returned with the rest of the Delegate Registration Form.***

**A PHYSICIAN MUST COMPLETE THE SECTION BELOW:**

**Delegate Name:** \_\_\_\_\_

**Medication:** \_\_\_\_\_ **Dosage:** \_\_\_\_\_

**Route of Administration:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Most Common Side Effects:** \_\_\_\_\_

**Inhaler/Epi-pen Patients Only:** In the case of Asthma or potentially life threatening illness will the patient be giving him/herself this medication?    **YES\***     **NO**

*\*IF YES, I certify that this patient is capable and has been instructed in the proper method of self-administration of medication.*

\_\_\_\_\_  
 Physician's Name (print)

\_\_\_\_\_  
 Physician's Signature

\_\_\_\_\_  
 Physician's Address

\_\_\_\_\_  
 Physician's Telephone Number

**PARENT/GUARDIAN MUST COMPLETE SECTION BELOW:**

I request the medication, in the original prescription labeled container to be administered to my child as prescribed by their physician.

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

\_\_\_\_\_  
 Date

**Inhaler/Epi-pen Patients Only:** In the case of Asthma or potentially life threatening illness will the patient be giving him/herself this medication?    **YES\***     **NO**

*\*IF YES, PLEASE SIGN BELOW: We the parents/guardian of the delegate acknowledge that the NJASC shall incur no liability as a result of any injury arising from the self-administration of medication by the delegate and that we shall indemnify and hold harmless the NJASC and its personnel against any claims arising out of the self-administration of medication by the delegate.*

Signature of Parent: \_\_\_\_\_

Date: \_\_\_\_\_