MEDICAL INFORMATION

Event: New York 11

Participant #: ______________________

For Official Use Only

- ☐ Cleared
- ☐ Need Written PMD OK
- ☐ Need Emergency Contact Info
- ☐ Need Signature
- ☐ Special Medical Needs

WAIVER OF NEGLIGENCE & RELEASE OF LIABILITY

I wish to participate in the Out of the Darkness Overnight that consists of an overnight walk using public streets. I understand that this is a nighttime event, and hazards can exist on the route and accidents may occur. I also acknowledge that I may be hurt or killed during the event not only from injury, but due to the level of physical exertion necessary to complete the walk, and that these risks of injury or death cannot be completely eliminated.

I AM VOLUNTARILY PARTICIPATING IN THIS EVENT WITH KNOWLEDGE OF THE DANGERS. IN CONSIDERATION FOR BEING PERMITTED TO PARTICIPATE IN THIS EVENT, I AGREE TO ASSUME ALL RISKS AND TO RELEASE, HOLD HARMLESS AND AGREE NOT TO SUE: THE AMERICAN FOUNDATION FOR SUICIDE PREVENTION ("AFSP"), OP3, INC. AND ANY OTHER BENEFICIARIES, SPONSORS, OFFICIALS, PARTICIPATING CLUBS, ORGANIZATIONS AND ALL OTHER PERSONS OR ENTITIES ASSOCIATED WITH THIS EVENT, INCLUDING THE EVENT MEDICAL SPONSOR, THE MEDICAL DIRECTOR AND MEMBERS OF THE MEDICAL TEAM(S), GOVERNMENT OR PUBLIC ENTITIES INCLUDING, BUT NOT LIMITED TO, THE DEPARTMENT OF TRANSPORTATION AND THEIR RESPECTIVE AFFILIATED ORGANIZATIONS AND ALL THEIR RESPECTIVE DIRECTORS, OFFICERS, AGENTS, EMPLOYEES AND MEMBERS (COLLECTIVELY, "THE RELEASEES"), FOR ANY CLAIM, LOSS OR LIABILITY THAT I MAY HAVE ARISING OUT OF MY PARTICIPATION IN THE EVENT OR WHILE ON THE PREMISES OF THE EVENT, INCLUDING BODILY INJURY, DEATH OR PROPERTY DAMAGE SUFFERED BY ME OR OTHERS, WHETHER CAUSED BY FALLS, CONTACT WITH OTHER PARTICIPANTS, CONDITIONS OF THE COURSE OR REST STOPS, NEGLIGENCE OR CARELESSNESS OF THE RELEASEES OR OTHERWISE, IN EACH CASE, TO THE MAXIMUM EXTENT PERMITTED BY APPLICABLE LAW.

I INTEND BY THIS WAIVER AND RELEASE TO RELEASE IN ADVANCE, AND TO WAIVE MY RIGHTS AND TO DISCHARGE ALL OF THE RELEASEES, IN EACH CASE TO THE MAXIMUM EXTENT PERMITTED BY APPLICABLE LAW, FROM ALL CLAIMS, LOSSES OR LIABILITIES FOR DEATH, BODILY INJURY OR PROPERTY DAMAGE THAT I MAY HAVE, OR WHICH MAY HEREAFTER ACCRUE TO ME, AS A RESULT OF MY PARTICIPATION IN THIS EVENT, EVEN THOUGH THAT LIABILITY MAY ARISE FROM NEGLIGENCE OR CARELESSNESS ON THE PART OF THE RELEASEES, FROM DANGEROUS OR DEFECTIVE PROPERTY OR EQUIPMENT OWNED, MAINTAINED OR CONTROLLED BY THEM OR BECAUSE OF THEIR POSSIBLE LIABILITY WITHOUT FAULT. I UNDERSTAND AND AGREE THAT THIS WAIVER AND RELEASE IS BINDING ON MY HEIRS, ASSIGNS AND LEGAL REPRESENTATIVES.

I understand that the Out of the Darkness Overnight walk requires good physical conditioning and confirm that I am physically capable of participating in this event and have not been advised otherwise. If I am aware of, or under treatment for, any physical infirmity, ailment or illness, my healthcare provider is aware of and has approved my participation in this event based upon accurate medical information. I understand that event medical staff is relying on the completeness and truthfulness of the medical information that I am furnishing to them.

I understand that I must abide by all decisions of the Medical Team and Medical Director regarding my ability to continue to participate in the Event in case of injury, illness or any Medical situation. In the event of injury, accident or illness during the event, I consent to receive medical treatment, as may be deemed advisable.

I acknowledge that the medical insurance information I have provided on this Medical Form is current and complete and that I am solely responsible for procuring and maintaining all medical insurance. I accept full responsibility for any costs incurred for medical treatment due to failure to maintain or carry insurance, or providing outdated or falsified insurance information. I understand that it is ultimately my responsibility to provide payment to any hospital/emergency response technicians/emergency transport company that may provide services to me as a result of injury/illness during the Event.

I HAVE CAREFULLY READ THIS DOCUMENT, INCLUDING THE WAIVER AND RELEASE, FULLY UNDERSTAND ITS CONTENTS AND VOLUNTARILY SIGN BELOW.

Participant Printed Name: ______________________

Signature of Participant: ______________________

PARENT/GUARDIAN WAIVER FOR MINORS (UNDER 18 YEARS OLD)

I, the undersigned parent, legal guardian or custodian for the above minor, on behalf of the minor, hereby join in the foregoing Waiver and Release and represent that he/she is, in fact acting in such capacity and agrees to save, hold harmless and indemnify each and all of the parties referred to above from all liability, loss, cost, attorney's fees, claim or damage whatsoever that may be upon said parties as a result of the minor's participation in activities described above.

Participant's Representative Name: ______________________

Participant's Representative: ______________________

IMPORTANT: Please complete and submit this form no later than Friday, May 6, 2011.
Mail to: AFSP - The Overnight, 110 Wall Street, 24th Floor, New York, NY, 10005, Attn: Medical Team

Confidential Emergency Medical Information

Receipt of this document by the Medical Team is mandatory for all participants.

Last Name	First Name	
Mailing Address	Suite/Apt. #	
City	State/Province	Zip/Postal Code
Phone ( )	Date of Birth Age	Weight

If your medical history includes any of the following conditions, your personal physician must be aware of your participation and provide you with written authorization to participate in the event. In that case, please submit your physician's written authorization along with this form: (Please check all conditions that apply and specify or describe each condition that you check.)

- ☐ Cardiac (heart) history
- ☐ High Blood Pressure (uncontrolled or on diuretic)
- ☐ Lung problems (asthma, emphysema, etc.)
- ☐ Diabetes (Type I and II)
- ☐ Renal (kidney failure, dialysis, etc.)
- ☐ Ob/Gyn (currently pregnant, childbirth within 90 days of event)
- ☐ Oncologic (chemotherapy within 6 months of event)
- ☐ Psychiatric Disorder
- ☐ Hematologic (bleeding or clotting disorder, etc.)
- ☐ Neurologic (seizure/epilepsy disorder, etc.)
- ☐ Surgery (any within 120 days of event)
- ☐ Other, Description:________________________________

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MEDICATIONS: List any medications that you currently take (or attach a list):__________________________________

MEDICATION REFRIGERATION: Place an * next to any of these medications that need refrigeration: ____________________
____

ALLERGIES (medication, food, environmental, etc.): ____
____

Will you have any special medical needs during the event? If yes, please explain: ______________________________
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EVENT EMERGENCY CONTACT

Name____

Participant #___________________________________

OTHER EMERGENCY CONTACT

Name____

Relationship ___________________________________

Phone (Day) ( ) __________________________

Phone (Evening) ( ) ________________________

PRIMARY PHYSICIAN(S)

Name ____

Phone ( ) _____________________________

Name ____

Phone ( ) _____________________________

INSURANCE INFORMATION

Company ______________________________________

Policy # ______________ Group # ______________

Phone ( ) _____________________________

If you are anticipating any surgery or medical procedures, or if there are any changes in your medical/physical condition, prior to the event, you are to notify The Overnight office and update your Medical Information in our records.

Based upon your medical history and/or any changes/updates you submit at a later date, you may be asked to obtain a written authorization from your personal physician before participating in the event.

NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGEMENT OF RECEIPT. The Out of the Darkness Overnight Notice of Privacy Practices provides information about how we may use and disclose protected health information about you under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA").

I hereby release the above medical information to the Medical Records Coordinator, the Event Medical Director and any other medical personnel who may need to care for me while on this event, and I acknowledge receipt of the Notice of Privacy Practices.

Signature of Participant or Guardian ____ Date _________________________

Important: Please remember to sign page 1 and page 2.

NOTICE OF PRIVACY PRACTICES

Out of the Darkness Overnight 2011

PLEASE REVIEW THE DOCUMENT CAREFULLY.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information, used and disclosed by reason of your participation in the Out of the Darkness Overnight in any form, whether electronically, on paper or orally, are kept properly confidential. “HIPAA” gives you, the patient, sufficient new rights to understand and control how your medical information is used. “HIPAA” provides penalties for covered entities that misuse personal health information.

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: qualification, treatment, transportation, emergency notification and health care operations.

QUALIFICATION: means review by the event medical staff of information and health records submitted in support of your application to participate.

TREATMENT: means providing, coordinating or managing healthcare and related services by one or more care providers. An example of this would include treating a sprained ankle.

TRANSPORTATION: means removal from the event (with or without medical records) by ambulance, paramedics or other vehicle to hospital or other treatment facility.

EMERGENCY NOTIFICATION: means notification by phone to the person or household designated by you, in the event of illness or injury.

HEALTHCARE OPERATIONS: includes the business aspects of running the event medical program, such as: quality assessment and improvement, auditing or cost-management.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Medical Team, Out of the Darkness Overnight:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction.

The right to reasonable requests to receive confidential communications of protected health information from us by an alternative means or at alternative locations.

The right to inspect and copy your protected health information.

The right to amend your protected health information.

The right to receive an accounting or disclosures of protected health information.

The right to obtain a paper copy of this disclosure notice from us on request.

This notice is effective as of January 1, 2005 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and make new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices by contacting us at the address listed below.

Please contact us for more information:
AFSP – The Overnight
110 Wall Street, 24th Floor
New York, NY 10005
Attn: Medical Team

For more information about HIPAA:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201
Toll Free (877) 696-6775