You are invited to participate in our 2020 Elko Junior Counselor Program. This program is designed to build the skills necessary to become a future leader for the bleeding disorders community. The Program is open to age 16-19.

Attached is the application for the 2020 Elko Junior Counselor program is scheduled for July 24th – 26th. The Training will take place during the day on Friday, July 24th in Elko, NV. Junior Counselors will travel to Elko for the Northern Nevada Family Weekend on July 23rd – 26th and play leadership roles throughout the weekend including leading activities, assisting with registration, activity set-up, and session monitoring.

Please fill out the application completely and email the completed application to either Betsy at bvandeusen@hemophilia.org no later than April 15th, 2020. If you cannot email the form back, please fax to 702.446.8134

Note: To participate as a Junior Counselor this summer, participants must be at least 16 years old, have submitted an online volunteer application and attend the July 18th training.

We look forward to seeing you! Questions? Call NHF Nevada at 702.564.4368
JC Participant Registration Form (please print)

Name of JC_____________________________ Gender (circle) M   F

Type of ID to be used at airport (Reno Participants only) __________________________

Please Check One:  □ Patient ______________ □ Sibling ______________________________

(Diagnosis)

Age (on 3/2/2019)_________ Date of Birth: ______________

Last Grade Finished in school: __________ JC Cell Phone: ______________

JC email ________________________________

Address__________________________________________

Street       City       State       Zip

Do you have any dietary restrictions at training? __________________________

Mother/Guardian(s) Name_____________________________________________________

Home phone __________ Work phone __________ Cell phone ______________

Email address: ____________________________________________________________

Father/Guardian(s) Name____________________________________________________

Home phone __________ Work phone __________ Cell phone ______________

Email address: ____________________________________________________________

EMERGENCY CONTACT: If parents cannot be reached, whom should we contact?

Emergency Contact__________________________________________________________

Home phone __________ Work phone __________ Cell phone ______________

Relationship to LIT/JC________________________________________________________

2nd Emergency Contact_______________________________________________________

Home phone __________ Work phone __________ Cell phone ______________

Relationship to LIT/JC________________________________________________________
CONSENT FOR MEDICAL TREATMENT

LIT/JC Name _____________________________________________________________
(Please Print)

To Whom It May Concern:

In the event that I can not be present or reached by phone, I hereby authorize the Executive Director for the Nevada Chapter of the National Hemophilia Foundation, or his/her agent, to execute any and all documents including any necessary releases on my behalf that might be required by any medical facility to perform required emergency care on the basis of any accident or illness sustained or incurred by my minor child while attending the Jr. Counselor Program (JC).

I further agree that I, acting on behalf of myself or my minor child, do expressly and forever waive and release The Nevada Chapter of the National Hemophilia Foundation and all their respective officers, employees, agents or representatives from any and all liability for personal injuries or damages sustained, incurred or arising from participation at the JC Training.

Signature of parent or guardian __________________________________________

Printed name ____________________________________________________________

Relationship to LIT _______________________________________________________

CHILD’S INSURANCE INFORMATION

If you have health and accident insurance coverage, list below.

Check here if your child does not have insurance: __________

Name of Insurance Company ______________________________________________

Address: __________________________________________________________________

Phone (___) __________ Policy Number __________________

Certificate Number __________ Medicaid Number ______________

Please attach a current legible copy of insurance card and/or Medicaid card.