Child & Adolescent Behavioral Health
Improving Lives Since 1976.

Application for 2020 Stark County Youth Led Prevention

Please complete and return these forms by email or in person.
For assistance or questions, please contact SCYLP Facilitator Hannah Cowie at scylp@childandadolescent.org or (330) 826-1560

Stark County Youth Led Prevention (SCYLP) is a youth-led, adult-guided leadership development group focusing on promoting and celebrating healthy lifestyles for youth. SCYLP is facilitated by Child and Adolescent Behavioral Health to empower students to impact their schools, neighborhoods, and communities. SCYLP is a safe place for youth to come together and encourage their peers to make healthy decisions through planning and implementing various prevention and leadership development activities.

Name: _____ Date of Birth: _____ Age: _____

Address:_____

Email:_____ Phone:_____

School: _____ Grade: _____ T-Shirt Size: _____

How can Youth Led Prevention help develop your skills or reach your goals?

What challenges facing Stark County youth should the group address?

Do you have other responsibilities or activities that may prevent you from attending meetings or participating in SCYLP events? Do you have transportation to meetings?

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Youth Member Participation Requirements

Stark County Youth Led Prevention (SCYLP) members will:

- Embrace opportunities to participate in trainings, community events, and develop leadership skills.
- Assist with identifying, developing and delivering trainings.
- Represent SCYLP to support and advance youth-led prevention programs throughout Stark County.
- Advocate for mental health issues relevant to Ohio youth, both regionally and statewide.
- Provide opportunities to recognize youth leaders making a difference in their communities.
- Attend all meetings unless reasonable circumstances apply, notifying the SCYLP coordinator of these circumstances as soon as possible.

If members do not meet the above requirements, they will meet with the SCYLP facilitator to discuss any challenges they may be experiencing. If the member continues to have difficulty meeting the requirements, they may be asked to step down from the coalition.

Youth Agreements

I understand that in order to maintain membership in SCYLP, I must agree to the following:

- I will engage in leadership roles and follow through on tasks assigned to me.
- I will attend all meetings or provide a valid excuse for special absences.
- I affirm that I am committed to living a substance-free and healthy lifestyle.
- I understand this a county-wide group representing Child and Adolescent Behavioral Health; and therefore there may be occasions where this adult leadership will make final decisions on aspects of youth activities to ensure that appropriate and effective strategies are being utilized.

I certify that the information contained in this application is true and complete. Furthermore, I understand that if I am not able to meet the above assurances, I should discuss this with SCYLP coordinator.

Youth Signature_____ Date _____

Parent/Guardian Signature _____ Date _____

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Parental Consent/Support Form

As the parent/guardian of _____ *(Youth full name)*, from now on referred to as *SCYLP member* or *Youth,* I support _____ *(preferred pronoun)* application to be a part of Stark County Youth-Led Prevention (SCYLP), a division of Child and Adolescent Behavioral Health.

By signing this form, I signify my understanding and recognition of the following:

- This is a separate and stand-alone program from any other youth-led prevention program in which SCYLP members may be involved.
- SCYLP members are expected to attend meetings and events unless a valid excuse is offered. I will ensure that all necessary transportation arrangements are made.
- SCYLP events may occasionally take place during the school day, but SCYLP members are discouraged from attending if doing so will harm their academic performance. Participation in any event that results in missing class requires an excused absence from the school/district.
- Medical bills and insurance coverage for accidents or illness while participating in any program or event under the Child and Adolescent Behavioral Health umbrella is the responsibility of SCYLP members and/or family/legal guardian.
- If a SCYLP member chooses to share a personal story, they **may** give their permission for Child and Adolescent Behavioral Health or SCYLP to include it in promotional media and marketing.

Finally, I give consent for _____ (Youth first name) to participate in SCYLP events and activities, including, but not limited to: meetings, regional trainings, and the *We Are the Majority* Rally.

WAIVER and RELEASE OF CLAIMS (Please READ Carefully): In consideration for the Youth being permitted to participate in this program and its associated events, I hereby agree to assume all risks associated with the Youth's participation and fully release Child and Adolescent Behavioral Health and its directors, officers, agents, volunteers and employees from any and all claims for any injury of any kind to the Youth or other damages that may occur as a result of the Youth's participation and agree not to file any lawsuit or otherwise make any claim against Child and Adolescent Behavioral Health or any of its directors, officers, agents, volunteers and employees for any such injury or other damages. I understand and agree that this Waiver and Release of Claims is binding on me, the Youth, and legal representatives.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Printed Name Best Contact Number

_____
Parent/Guardian E-Mail

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2020 Youth Medical Information & Parent/Guardian Consent REQUIRED

_____

Youth Last Name First Name Date of Birth

List all medical conditions, allergies and medications currently taken by the above-named youth:

Persons to contact in case of an emergency:

_____
Name Relationship to youth

_____
Phone No. 2nd Phone No.

_____
Name Relationship to youth

_____
Phone No. 2nd Phone No.

Medical Emergency Consent

In the event of a medical emergency involving the Youth where reasonable attempts to contact one of the above-listed individuals is unsuccessful, I give my consent for (1) administration of any treatment deemed necessary by Dr. _____ (preferred physician) at _____ (phone number) or Dr. _____ (preferred dentist) at _____ (phone number) or in the event preferred medical professional is not available by _____ (preferred hospital) or the nearest emergency medical location. I understand that all medical bills and insurance coverage for accidents or illness while participating in any event with Stark County Youth-Led Prevention (SCYLP) is my responsibility.

Medication Self-Administration

_____ (initial if applicable) I give my consent for the Youth to self-administer medications listed below:

I do hereby release Child and Adolescent Behavioral Health and its affiliates, officers, agents, volunteers, and employees from any and all claims of injury and damages that may occur in connection with the Youth's self-administering of medications.

Insurance Carrier: _____ Policy Number: _____
Medicare Number (if applicable): _____ Medicaid Number (if applicable): _____

Parent/Guardian Signature: _____ Date: _____