

# TEEN ADVISORY COUNCIL HEALTH HISTORY

FOR TAC MEMBER, TO BE COMPLETED BY PARENT OR GUARDIAN

STUDENT NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ AGE \_\_\_\_\_ GENDER: MALE FEMALE

HOME ADDRESS \_\_\_\_\_  
STREET & NUMBER CITY STATE ZIP

HOME PHONE \_\_\_\_\_ GRADE (FALL 2019) \_\_\_\_\_ SCHOOL \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_ CELL PHONE \_\_\_\_\_

MOTHER'S WORKPLACE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

FATHER'S NAME \_\_\_\_\_ CELL PHONE \_\_\_\_\_

FATHER'S WORKPLACE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

PARENT'S EMAIL ADDRESS \_\_\_\_\_

PARENTS WHO LIVE SEPARATELY CAN USE THIS LINE TO PROVIDE THE INFORMATION FOR (CIRCLE): MOTHER FATHER

HOME ADDRESS \_\_\_\_\_  
STREET & NUMBER CITY STATE ZIP

IN CASE OF AN EMERGENCY, NOTIFY (SOMEONE OTHER THAN PARENT) \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

OPERATIONS OR SERIOUS INJURIES (DATES) \_\_\_\_\_

DISABILITY OR CHRONIC OR RECURRING ILLNESS \_\_\_\_\_

ACTIVITIES ENCOURAGED OR LIMITED BY PHYSICIAN \_\_\_\_\_

DIETARY MODIFICATIONS/KNOWN ALLERGIES \_\_\_\_\_

CURRENT MEDICATIONS \_\_\_\_\_

NAME OF DENTIST/ORTHODONTIST \_\_\_\_\_ PHONE \_\_\_\_\_

NAME OF FAMILY PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

DATE OF PHYSICAL EXAMINATION \_\_\_\_\_

DO YOU CARRY FAMILY MEDICAL/HOSPITAL INSURANCE? \_\_\_\_\_ YES \_\_\_\_\_ NO

IF SO, INDICATE: CARRIER \_\_\_\_\_ POLICY OR GROUP NUMBER \_\_\_\_\_

ANY ADDITIONAL HEALTH RELATED INFORMATION \_\_\_\_\_

THIS HEALTH HISTORY IS CURRENT SO FAR AS I KNOW, AND THE PERSON HEREIN DESCRIBED HAS PERMISSION TO ENGAGE IN ALL PRESCRIBED TEEN ADVISORY COUNCIL ACTIVITIES EXCEPT AS NOTED. AUTHORIZATION FOR TREATMENT: I HEREBY GIVE PERMISSION TO THE MEDICAL PERSONNEL SELECTED BY THE PROGRAM MANAGER TO ORDER X-RAYS, ROUTINE TESTS, TREATMENT, AND NECESSARY TRANSPORTATION FOR MY SON OR DAUGHTER. IN THE EVENT I CANNOT BE REACHED IN AN EMERGENCY, I HEREBY GIVE PERMISSION TO THE PHYSICIAN SELECTED BY THE PROGRAM MANAGER TO SECURE AND ADMINISTER TREATMENT, INCLUDING HOSPITALIZATION, FOR MY SON OR DAUGHTER NAMED ABOVE. EMERGENCY AUTHORIZATION VALID FROM AUGUST 2019 THROUGH MAY 2020.

**SIGNATURE OF PARENT OR GUARDIAN**

I ALSO UNDERSTAND AND AGREE TO ABIDE WITH ANY RESTRICTIONS PLACED ON MY TEEN ADVISORY COUNCIL ACTIVITIES.

**SIGNATURE OF PARTICIPANT**

# TEEN ADVISORY COUNCIL LIABILITY & PHOTO RELEASE

I understand that Youth Resources of Southwestern Indiana, Inc., University of Evansville, Ivy Tech Community College, and First Federal Bank cannot assume any liability for people attending these TAC events (TAC kick-off event and/or TAC events/meetings). I waive, release and discharge Youth Resources of Southwestern Indiana, Inc., Ivy Tech Community College, First Federal Bank and the University of Evansville from any and all claims of liability from my participation in these events (TAC kick-off event and/or TAC events/meetings). I also give permission for my picture to be used in any Youth Resources promotion.

**APPLICANT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_



# 2019-20 TEEN ADVISORY COUNCIL CONTRACT

*I understand that my appointment to the Teen Advisory Council is not only an honor but also a **responsibility**. As a member, I will work toward achieving the Council's goals:*

- To identify problems teenagers are facing
- To suggest solutions to these problems
- To work toward solving these problems
- To represent a cross-section of diverse interests and activities
- To increase awareness of youth issues in the adult community
- To impact the adult community by showing that teens can be a source of solutions
- To gain leadership experience
- To be involved in meaningful community service projects
- To develop friendships and contacts from other area high schools
- To live a tobacco-, drug-, and alcohol-free life
- To complete my assigned requirements as listed in the TAC bylaws

***In addition, I will attend all TAC trainings, meetings & special events, work on Council projects, serve on selected committees, and be a spokesperson for Youth Resources and its efforts to involve young people in meaningful community service, leadership development & civic experiences.***

*Finally, I realize that if I have more than two absences from Council meetings during a semester and/or participate in fewer than the required community service hours, shadowing meetings and/or social events determined by the Council, **I will lose my eligibility to continue as a Council member** unless I am reinstated by the Teen Advisory Council's Executive Committee after completing the appeal process as set forth in the TAC bylaws.*

\_\_\_\_\_ **APPLICANT SIGNATURE**

\_\_\_\_\_ **DATE**

**Parent/Guardian:**

*I have read the above contract and understand the commitment that is required by the above-signed student. I will support his/her efforts and will help him/her to fulfill this obligation in whatever capacity I am able.*

\_\_\_\_\_ **PARENT/GUARDIAN SIGNATURE**

\_\_\_\_\_ **DATE**