



REALITY CHECK

REGISTRATION

Please review and complete the following forms. All forms must be completed for participation in Reality Check. For further information regarding Reality Check please give us a call at BRiDGES @ 315-697-3947. Please return completed form to BRiDGES/Reality Check PO Box 389 Oneida, NY 13421 or to vwebb@bridgescouncil.org

DATE: _____

Name: _____ **AGE:** _____ **T-SHIRT SIZE:** XS S M XL XXL 3XL

Preferred Name: _____ **BIRTHDAY:** _____

Preferred Gender Pronouns: (please circle/*optional*)

She/Her/Hers He/Him/His They/Their/Theirs Other: _____

How do you identify yourself?(*optional*)

Gender: _____

SCHOOL: _____ GRADE LEVEL: _____

COMPLETE HOME ADDRESS: _____

YOUTH CELL PHONE: _____ YOUTH EMAIL: _____

PARENT NAME: _____ PHONE: _____

PARENT EMAIL: _____

PARENT NAME: _____ PHONE: _____

PARENT EMAIL: _____

EMERGENCY CONTACT: _____ PHONE: _____

Special Needs: Please indicate any special needs or disabilities that we should know about. Include any relevant information with this form.

Special Dietary Needs: Please indicate any special dietary restrictions such as vegetarian or food allergies.

CONSENT FOR YOUTH PARTICIPATION

YOUTH'S NAME: _____

I hereby request and consent that my child or ward, _____,
YOUTH'S NAME

is permitted to travel to and from and participate in the Reality Check trainings, events and meetings. I understand the following:

- Trainings, meetings, and events are designed as a means to educate and update the New York youth advocates on the latest techniques in tobacco prevention and equip them to take leadership in their communities with the skills and knowledge they gain from these meetings and trainings.
- I agree that no official or employee associated with the training will be held responsible for any injuries or damages occurring while my child is traveling to or from or participating in trainings, meetings, or events. I do hereby hold harmless the sponsoring agencies, their officials, divisions and agents against any and all liability, damage, loss, claims or demands which arise out of or are in any way connected with my child or ward's participation.
- I hereby authorize any official of the training or designated chaperone to consent to emergency medical treatment as necessary for the health and safety of my child. I further agree that no official or volunteer will be held responsible for injuries or damages arising from the provision of any such emergency medical treatment. I do hereby agree to indemnify and hold harmless the sponsoring agencies, their officers, divisions and agents from any and all liability, damage, loss, claims, or demands and actions of any nature whatsoever, including attorney's fees, which arise out of or are in any way connected with the provision of such emergency medical services.

The nature of Reality Check trainings, meetings, and events have been reviewed with me and I hereby give my approval.

I further grant permission for (YOUTH'S NAME) _____ to appear in person or in voice, video or photographic presentation for radio, television, websites, or print media reports and/or media campaign(s) resulting from participation in the New York State Youth Reality Check events and also to complete confidential or anonymous surveys and participate in interviews for evaluation purposes.

Participant Signature _____ Date: _____

County Represented _____

Parent/Guardian Signature _____ Date: _____

Parent/Guardian Name (Printed) _____



REALITY CHECK

MEDICAL RELEASE FORM

YOUTH'S NAME: _____ COUNTY: _____

On rare occasions, an emergency requiring hospitalization and/or surgery develops. As a general rule, anesthesia may not be administered to or operation performed without written permission by the parents or guardians. Therefore, in order to prevent a dangerous delay, if an emergency does occur and we are unable to contact the parents or legal guardian, the parent/guardian is asked to sign the release form below.

In the event of injury or illness to my son/daughter/ward,

(YOUTH'S NAME)

(DATE OF BIRTH – MM/DD/YY)

I hereby authorize official meeting staff to secure whatever treatment is deemed necessary and, if recommended by an attending physician, the administration of an anesthetic or surgery.

Is the minor listed above allergic to any medications? Yes _____ No _____

If yes, please list: _____

Please list any medical condition of which staff should be aware: _____

Note: Medications will be held by the chaperone. Medications must be in original containers and have the youth's name and dosing instructions clearly identifiable on the label – this includes prescribed as well as over-the-counter medications.

Hospitalization Insurance Company

Name of Emergency Contact/Relationship to Youth

Hospitalization Insurance Policy #

Home /Cell Telephone Number of Contact

Work Telephone Number of Contact

Please identify special limits to treatment, if any: _____

Parent or Guardian's Signature

Date

Parent or Guardian's Name (Printed)

County Represented

PLEASE ATTACH COPY OF THE YOUTH PARTICIPANT'S MEDICAL INSURANCE CARD, IF POSSIBLE. Front & Back



REALITY CHECK

YOUTH CODE OF CONDUCT

The following code of conduct will be enforced at every youth training, meeting, and event that is held for Reality Check. All participants and their parent or guardian must sign this document before the youth can participate in the training.

- **The possession and or use of weapons, alcoholic beverages, tobacco products, and illegal drugs, or remaining in the presence of individuals who are using or taking these items is prohibited.**
- **Any gambling is prohibited. Gambling includes card playing, dice or other gambling activities that include betting or money exchange. Games that do not include betting may be allowed at adult's discretion.**
- **Any sexual contact, which occurs within the timeframe of Reality Check Youth trainings, meetings, or other sponsored events, is prohibited. *This includes but is not limited to dance moves that are sexual in nature. This is at the discretion of any coordinator or other adult supervisor/chaperone. A warning will be given.***
- **Dress Code:** May vary depending on the nature of the event, please check with your coordinator for special situations such as legislative visits, public hearing, professional meetings and the like. All clothing should fit appropriately and worn in a way that is not unduly revealing. Undergarments and body parts that are considered private should be fully covered. Shorts or skirts must be well-fitted at the waist or upper hip and fully extend to mid-thigh. No suggestive, abusive inappropriate language or designs, or language that includes put-downs (i.e. I'm with stupid, etc.). The wearing of clothing or jewelry that projects violence, drugs or sexual innuendo is strictly forbidden. **You will be asked to change if you do not adhere to these guidelines.**
- **Entering the lodging room and/or lodging floor, dorm or sleeping space of the opposite gender is prohibited for the duration of Reality Check Events. *This includes free time, any time before curfew, during registration, etc.***
- **All participants will adhere to the curfew stated in the Reality Check agenda and will be in their assigned rooms/space by the set curfew.**
- **Any behavior that violates any of the laws of the United States or the State of New York or any local ordinance is prohibited.**
- **All participants are to remain on the grounds, in the conference buildings, and other approved designated areas for the duration of the event.**
- **All participants are to show respect for the property of others and the facility in which the event is being held.**
- **When attending a training/meeting, participation and punctuality is considered mandatory by all participants.**

I have read the above Code and reviewed it with my parent/guardian. We understand that if it is determined I have violated the Code my parents will be called to pick me up or provide transportation home for me (at their expense) from the training and I will no longer be able to attend overnight events for Reality Check. The responsibility for making this determination is vested in the NYS Department of Health staff and the Program Coordinator.

Participant's Name (please print) _____

Participant's Signature _____ Date _____

Parent or Guardian's Signature _____ Date _____

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