

YOUTH ENGAGEMENT

PARAMETERS FOR YAC ENGAGEMENT AND TEEN VOLUNTEERISM



VOLUNTEER - DEFINITIONS

- 1: a person who VOLUNTARILY undertakes or expresses a willingness to undertake a service:
 - a : one who enters into military service voluntarily
 - b: (1) : one who renders a service or takes part in a transaction while having no legal concern or interest
(2) :one who receives a conveyance or transfer of PROPERTY without giving valuable consideration

2 : a volunteer plant



3: *CAPITALIZED* [*VOLUNTEERS OF AMERICA*] : A MEMBER OF A QUASI-MILITARY RELIGIOUS AND PHILANTHROPIC ORGANIZATION FOUNDED IN 1896 BY COMMANDER AND MRS. BALLINGTON BOOTH

DEFINITION OF THE YOUTH ADVISORY COMMITTEE

Who will you serve?

Where will you serve?

When will you serve?

GOALS - Do you have any?

ARE YOU READY... LEGALLY?



Permission to
Join



Permission to
Treat



Permission to
Transport

SET THE STAGE

Purpose

- Mission
- Vision

Boundaries

- Appropriate Activities
- Locations

Budget

- Do you have one?
- Where will future monies come from?

PARENTS

- One or Two
- Vested Interest
- Inclusive

PROGRAM PLANNING

- “Everyone is Doing It!”
- Kid Friendly
 - Appropriate?
 - Safe?
- Kid Chosen
 - Not your Party!
- Benefactor (s)
 - Who’s Who?

CHECK YOUR CALENDARS

- School
- Social/Community
- You

GET THE WORD OUT

Marketing 101

- Demographics
- Resources
- Calendar
- Share the load

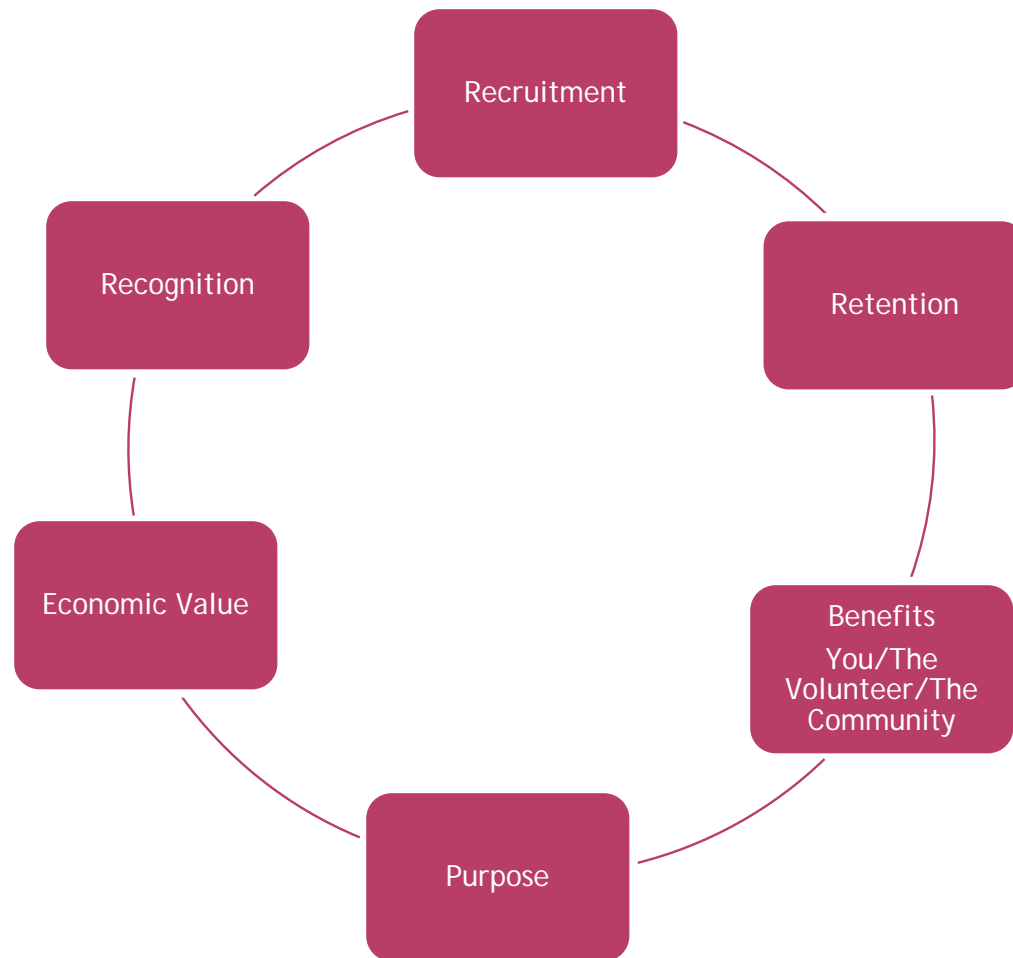
Stay In Touch

- Follow Up

Be In Touch

- Rule of Three

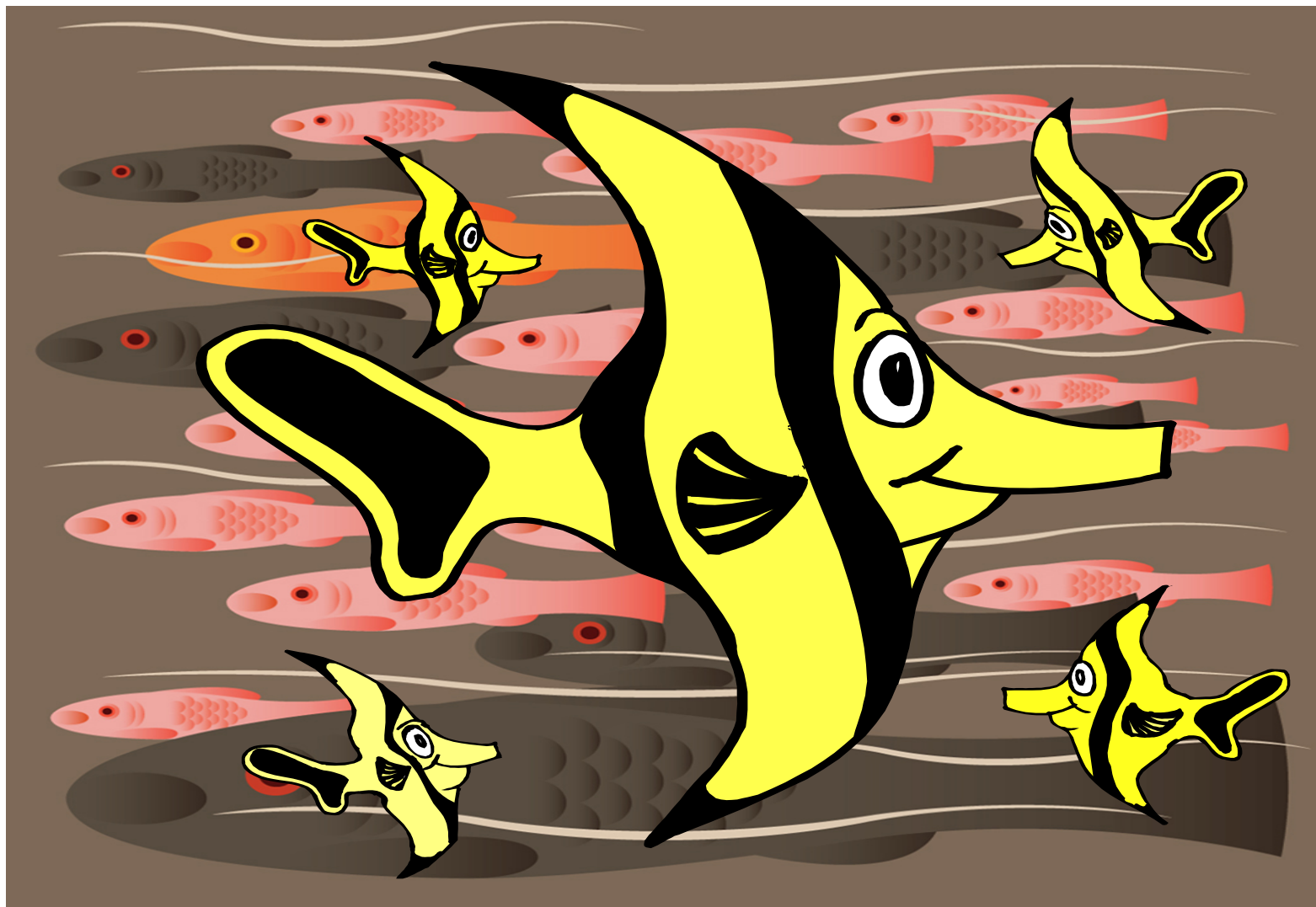
VOLUNTEERISM



SERVICE LEARNING

- ◉ Time for reflection
- ◉ Intentionally connect
- ◉ Meet real community needs
- ◉ Opportunity to lead
- ◉ Acknowledge

REMEMBER... FISH!



OPTIONS

They
have so
many
options!



RESOURCES

❖ Hands On Network
www.handsonnetwork.org

❖ Corporation for National and
Community Service
www.nationalservice.gov

❖ Your Local United Way

❖ Your I.S.D.

❖ Each Other!

JANET FERGIN
PROGRAM COORDINATOR
THE C.A.M.P.
906-293-3226
JFERGIN@EUP.K12.MI.US

The C.A.M.P.

Counseling and Medical Place
School-Based Health Center

Parent/Guardian Consent Form

Name (Last Name, First Name, M.I.)	Birth Date	Age	Sex	Grade	School
Address	City	Zip Code	Student Telephone	Today's Date	

Race/Ethnicity (optional)

Black/African American White Hispanic/Latin Native American / Native Alaskan Asian Native Hawaiian/Pacific Islander

Parent/Guardian: Last Name	First Name	M.I.	Relationship to Student
Daytime Telephone #	Work Telephone #	Cellular #	Parent Email Address
Name of Emergency Contact	Relationship	Telephone #	
Name of Student's Physician/Clinic		Telephone #	
Name of Student's Dentist		Telephone #	
Insurance* (Please include a copy of the insurance card - front and back)			
<input type="checkbox"/> Medicaid <input type="checkbox"/> BCBS <input type="checkbox"/> NGS Insurance <input type="checkbox"/> MI Child <input type="checkbox"/> TRICARE <input type="checkbox"/> UPHP <input type="checkbox"/> No Insurance <input type="checkbox"/> Other _____			
I.D. Contract #	Policy/Group #	Student Relationship to Policy Holder	
Policy Holder Name (Last Name, First Name, M.I.)			
Address	City	State	Zip Code

As legal parent or guardian I consent to the following:

- The above named may receive services at the C.A.M.P. School-Based Health Center by the Physician, Physician's Assistant or Nurse Practitioner, and/or mental health provider. This consent remains active until rescinded or the student reaches age 18.
- I understand that any changes to this consent, or to rescind this consent, I must submit my wishes in writing and ensure that it is received by Health Center staff.
- The C.A.M.P. may release information regarding treatment to third party payers or others for the purpose of receiving payment for services. If required by law, separate release forms will be used at time of service. Billing information will be shared to the providers of care.
- Both the C.A.M.P. and my child's primary care provider may exchange health information for the purpose of continuity of care according to State and Federal laws.
- The C.A.M.P. may obtain a copy of the above named student's/patient's immunization record from the student's/patient's school office, primary provider's office and or local health department.
- The C.A.M.P. may obtain information from Tahquamenon Area Schools regarding my child's grades, disciplinary action, and/or school attendance for program and statistical purposes. (NO student identifiers will be used. Each child's identity will remain confidential)
- I am under no obligation to have my child use the clinic services.
- I authorize the C.A.M.P. to disclose protected health information regarding this visit to other entities for continuation of treatment, payment, and health care operations. I have been provided with a copy of the summary Notice of Private Practices. I authorize that payment be made on my behalf to the C.A.M.P. I further agree to pay to the best of my ability any and all expenses not covered under the policy. I understand that the C.A.M.P. has a sliding fee scale for which I may qualify.

PLEASE NOTE: **NO ONE will be turned away for inability to pay.**



By signing this consent form, I certify that I am the parent/legal guardian of the student named above and I am registered with the school as such.

Signature of Parent/Guardian _____ Date: _____ -Over-

Student Medical History: Please check yes or no

- | | | | | | |
|---------------------------|------------------------------|-----------------------------|---------------------|------------------------------|-----------------------------|
| Bee sting allergies | <input type="checkbox"/> yes | <input type="checkbox"/> no | Seizures (epilepsy) | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Anemia | <input type="checkbox"/> yes | <input type="checkbox"/> no | Stomach problems | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Seasonal allergies | <input type="checkbox"/> yes | <input type="checkbox"/> no | Heart problems | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Asthma | <input type="checkbox"/> yes | <input type="checkbox"/> no | Bladder problems | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Diabetes | <input type="checkbox"/> yes | <input type="checkbox"/> no | Cancer | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Eczema/rashes | <input type="checkbox"/> yes | <input type="checkbox"/> no | Headaches/migraines | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| ADD/ADHD | <input type="checkbox"/> yes | <input type="checkbox"/> no | High blood pressure | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Sickle cell disease/trait | <input type="checkbox"/> yes | <input type="checkbox"/> no | Fainting | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Pounding of heart | <input type="checkbox"/> yes | <input type="checkbox"/> no | Pneumonia | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Shortness of breath | <input type="checkbox"/> yes | <input type="checkbox"/> no | Kidney disease | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Frequent urination | <input type="checkbox"/> yes | <input type="checkbox"/> no | Painful joints | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Nosebleeds | <input type="checkbox"/> yes | <input type="checkbox"/> no | Backaches | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Frequent sore throats | <input type="checkbox"/> yes | <input type="checkbox"/> no | Thyroid disease | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Psychological disorder | <input type="checkbox"/> yes | <input type="checkbox"/> no | | | |

Daily Meds _____
 Condition for Meds: _____
 Medication Allergies: _____
 Food Allergies: _____
 Surgeries: _____
 Hospitalizations: _____
 Other health problems: _____

Family Medical History	
Check any illnesses that relatives (i.e. mother, father, aunt, uncle, grandparents, sibling) and note which relative has them	
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Cancer
<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Diabetes (high blood sugar)
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma/Emphysema/Bronchitis	<input type="checkbox"/> Seizures
<input type="checkbox"/> Death under age 50 – Cause:	<input type="checkbox"/> Kidney or Thyroid Disease
<input type="checkbox"/> Sickle Cell Anemia/Blood problems	<input type="checkbox"/> Other

Parental consent is not needed for crisis intervention and emergency care

Parental consent is required for the following services provided the student/patient is under the age of 18:	Current Michigan Law allows for confidential services to minors in these areas:
<ul style="list-style-type: none"> ➤ Physical exams for school, sports and camp. ➤ Treatment for acute & chronic illness & injuries ➤ Vision/hearing screenings and follow-up ➤ Oral/dental screening and follow-up ➤ Immunizations ➤ Basic laboratory services & tests ➤ Administration of medication ➤ Individual, group, family and community education ➤ Referrals for specialty services 	<ul style="list-style-type: none"> ➤ Gynecological services ➤ Pregnancy testing and referrals ➤ Sexually transmitted disease screenings, treatment and counseling ➤ HIV screening and referrals ➤ Physical/sexual abuse counseling and referrals ➤ Crisis Intervention ➤ Substance abuse education, counseling and referrals ➤ Mental health assessment, counseling and referrals for Students over 14 years of age.

As part of a comprehensive, best practice visit, student’s 12 years and older will take the Rapid Assessment for Adolescent Prevention Services (RAAPS) by their 3rd visit. This is a **confidential**, 15-question needs survey that covers dietary, safety, bullying, substance use, sexual, and other risk behaviors. This allows the provider to quickly assess if there are risk areas the patient needs counseling around during their visit. For more information about the RAAPS, go to www.raaps.org.

Can we help? Does your family have immediate needs for assistance?

___ **Health Insurance for my child**

___ **Housing**

___ **Food**

___ **Other:** _____

This information is confidential and will only be shared with appropriate resources with your consent. We will call you.

LIMITATION OF SERVICES:

NO birth control pills or devices will be dispensed or prescribed; NO abortion counseling, referrals or services are provided.



The C.A.M.P.

Counseling and Medical Place

Student Permission and Release of Liability Form

Activity: Why Try

Dates: Thursday, June 23 through Thursday, August 25, 2011 (Thursdays only)

I give permission for my child _____ to attend the "Why Try" Program sponsored and hosted by The CAMP (Counseling and Medical Place) and lead by Wendy Young, LMSW, BCD. I understand lunch will be provided for my child free of charge.

I release liability from The C.A.M.P, its affiliates and adult chaperone(s) for the entirety of this activity. In the event of a medical emergency I understand that I will be contacted as soon as possible.

I have completed the Parent/Guardian Consent form.

I give permission for my child to leave school property with the group in the event of an occasional trip (may be walking to Timber Charlie's for lunch on occasion).

I give permission for photos of my child to be used by The C.A.M.P. for promotional reasons:

Facebook Newberry News C.A.M.P Web Page on TAS Website Other

Parent/Guardian Signature

Phone

Emergency Contact Name & Phone

The C.A.M.P.

Student Contract

I _____ understand that I have been given an opportunity to attend Why Try. I promise to be on my best behavior during the entirety of all activities. I also understand that if I do not follow the guidelines below my parent/guardian will be called to pick me up from this event.

I promise to respect the views and opinions of others.

I promise to respect the personal property of others.

I promise to conduct myself in a safe manner at all times and not cause harm to others.

I promise to inform my Instructor or other adult if I feel I've been mistreated.

Student Signature

Date