**Youth Tobacco Action Group**

**Membership Form**

*A program of Tobacco Free for a Healthy NJ*

**PERMISSION SLIP AND RELEASE FORM**

**FOR ACTIVITY PARTICIPATION IN Youth Tobacco Action Group PROGRAMS AND ACTIVITIES**

|  |  |
| --- | --- |
| **Date:** |  |
| **Participants Name:** |  |
| **Grade & Age**  |  |
| **School** |  |
| **Cell Phone:** |  |
| **Email:**  |  |
| **Address:** |  |
| **County:** |  | **City:** |  | **Zip code:** |  |
| **Coalition Name:**  |  |
| **Coalition Youth Coordinator/Contact Person**:  |  |
| **Phone:** |  |
| **Email**  |  |
| **Youth Group Name:**  |  |

I hereby grant permission for my child to participate in the Youth Tobacco Action Group of \_\_\_\_\_\_\_\_. I understand that my child participates in these activities at their own risk and that Youth Tobacco Action Group of \_\_\_\_\_\_\_\_and NJPN are not liable for any injury, personal or otherwise, to my child or caused by my child. Should any problems arise concerning the behavior of my child, I understand that I am expected to pick up my child from the location of the event or activity at my own expense. I recognize that Youth Tobacco Action Group of \_\_\_\_\_\_\_\_uses photographs and video images of events for publicity materials such as the Youth Tobacco Action Group of \_\_\_\_\_\_\_\_and TobaccoFreeNJ.com website, newspapers, newsletters, and Facebook page. I understand that by signing below I am granting permission for photo/video images of my child to be taken and used for such purposes. I authorize the treatment, by a qualified and licensed medical doctor, of the minor listed above in the event of any medical emergency which, in the opinion of the attending physician, is necessary and I/we cannot be reached after reasonable effort has been made to secure my personal consent. I understand that I am responsible for any medical expenses.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Parent or Legal Guardian*

Work Phone: (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_ [ ] *please contact this number first*

Cell Phone: (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_ [ ] *please contact this number first*

|  |
| --- |
| **Additional Emergency Contact Information** |
| **Emergency Contact #1:** |  |
| **Relationship to Participant:** |  |
| **Day Phone:** |  | **Night Phone:** |  |
| **Emergency Contact #2:** |  |
| **Relationship to Participant:** |  |
| **Day Phone:** |  | **Night Phone:** |  |

|  |
| --- |
| **Medical Information Form** |
| **Special Medical Conditions:** *allergies, chronic illness, or other conditions:* |
|  |
| **Any medical or information we might need to know:** *Special needs/considerations, concerns* |
|  |

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| --- |
|  **ABOUT YOU** *(to be filled out by youth)* |
| **Please tell us in a sentence or two why you want to become a member of the Youth Tobacco Action Group of \_\_\_\_\_\_\_\_\_**  |
|  |
| **What experience, interests, skills, and/or talents might you bring to the Youth Tobacco Action Group \_\_\_\_\_\_\_\_?** |
|  |

**How do I want to be involved?**

**(Circle All that Apply)**

|  |  |  |
| --- | --- | --- |
| **State Action Group** | **Press/Media Rep.** | **County Leadership Position** |
| **Recruiting Other members** | **Mentoring Younger Kids** | **Leading Community Activities** |
| **Newsletter Writing** | **Community Service** | **Flyer/Poster** |
|  **Public Speaking** | **Other** | **Other** |

