



Dear *Parent/* Guardian,

Your child/student has expressed interest in joining Vista Community Clinic's Spreading Tobacco Control Advocacy Through Youth (STAY) Woke Club at Vista High School. STAY Woke is a voluntary program designed to empower young people to challenge the influences of the tobacco industry on their peers and community, gain leadership skills and understand the importance of civic engagement within their community.

Vista Community Clinic (VCC) is your community health center. Our mission is to **advance community health and hope by providing access to premier health services and education for those who need it most.** VCC offers health care services such as Pediatrics, Family Medicine, Dental and Behavioral Health throughout North San Diego County, as well as Riverside and Orange county communities. At VCC we understand that the health our communities is also a driving force in our individual health and wellness. Through our Health Promotion Center, we offer programs and services outside the medical office.

VCC's Tobacco Control Program works with community members and partners to promote smoke and tobacco free environments, prevent youth access to tobacco products and help people to stop smoking through public health policy.

VCC staff work in close partnership with Vista High School and Migrant Education Program staff to organize and facilitate each STAY Woke Club meeting.

Your child/students participation will bring many benefits to advance their academic achievement and personal growth. We look forward to working with them. The attached Membership Application and Release Forms must be completed and returned for your child/student to participate. Please feel free to contact us at any time.

Regards,

Carina Esquivel  
(760) 631-5000 Ext. 7158  
[Carina.esquivel@vcc.org](mailto:Carina.esquivel@vcc.org)



# STAY Woke Membership Application



## Student Info

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Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Grade \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email \_\_\_\_\_

Gender:  Female  Male  Gender Nonconforming: \_\_\_\_\_

Preferred Pronouns:  She/Her  He/Him  They/Them  Other: \_\_\_\_\_

Birthday \_\_\_/\_\_\_/\_\_\_ Are you bilingual?  Yes  No If yes, what languages? \_\_\_\_\_

Are you on Social Media?  Yes  No If yes, which sites: \_\_\_\_\_

How is it best to contact you? Please check all that apply:

Home Phone  Cell Phone  Texting  Email  DM  Texting App: \_\_\_\_\_

We would like to get to know you! Please tell us some of your interests, hobbies, and talents:

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Are you interested in working on community projects outside of school hours?  Yes  No

What is your schedule availability Monday-Friday after school and on weekends?

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Please tell us why you would like to be a part of Stay Woke.

Do you currently use alcohol, tobacco, and/or other drugs?  Yes  No

## Parents/Guardian Info

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Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

What is it best way to contact you?  Home Phone  Cell Phone  Texting  Email



Vista Community Clinic  
*STAY Woke*  
**Permission Slip**

With your permission, your child/student wishes to participate in the Spreading Tobacco Control Advocacy Through Youth (STAY) Woke Club. Club activities kick-off in September 2020 and will continue through June 3, 2021.

This Club will provide leadership training, tobacco and other drug education, and exciting opportunities for your child/student to participate in community service activities. Each meeting, training and activity will be supervised by Vista Community Clinic (VCC) staff members.

If you have any questions regarding any of the activities, please contact the staff listed below.

- Carina Esquivel, 760-631-5000 x 7158 or [Carina.Esquivel@vcc.org](mailto:Carina.Esquivel@vcc.org)
- Nancy Rocha, 760-631-5000 x 1050 or [nrocha@vcc.org](mailto:nrocha@vcc.org)

I give permission for my child \_\_\_\_\_ to participate in the STAY Woke Club.

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

Vista Community Clinic  
1000 Vale Terrace, Vista, CA 92084

# AUTHORIZATION FOR USE OR DISCLOSURE OF PARTICIPANT IMAGE IN VIDEO, PHOTOGRAPHIC FOOTAGE and PROTECTED HEALTH INFORMATION

I, \_\_\_\_\_, authorize Vista Community Clinic and its affiliates, subsidiaries, divisions, members, directors, officers, agents, employees, and independent contractors (referred to collectively herein as "VCC"), to use and disclose my image in photographs and/or video footage taken of me and to disclose protected health information about me, including my name, age, treatments received, diagnosis, and results in promotional, marketing, instructional, or educational projects ("Projects") that show how the programs of the Vista Community Clinic help people throughout its service area.

The Projects may be disclosed to governmental agencies, corporate or individual donors, foundations, and to the public in general, and may include, but are not limited to: videos, newsletters, websites, reports, brochures, press releases, presentations, exhibits, displays, PowerPoint presentations, social media activity, annual reports, applications, fund-raising activities, and appeal letters. I waive any rights of compensation or ownership of such photographs and/or video footage taken of me.

This authorization may be revoked at any time if notification of such revocation is submitted **in writing** to Vista Community Clinic. Such revocation may either be hand-delivered or mailed to Vista Community Clinic at 1000 Vale Terrace Vista, CA 92084. I understand that I will not be able to revoke this authorization if the VCC has already taken action in reliance on the authorization and, even if I revoke my authorization, VCC may not be able to remove my image or my protected health information from Projects already disclosed. I am aware that my image and protected health information disclosed pursuant to this authorization may be re-disclosed by the recipient of the information, at which time my image and protected health information may no longer be protected by state federal privacy regulations and could be re-disclosed without my authorization. **I understand that photographs and/or video footage of me and other protected health information about me may be used in social media sites and that, once posted on the internet, such images and information are almost impossible to recall.**

*Please initial here*

I am aware that VCC may receive direct or indirect remuneration in connection with the use or disclosure of my image and information about me for the purposes stated herein.

I understand that VCC cannot require me to sign this authorization in order for me to receive treatment, that my signature on this authorization is voluntary, and that I may refuse to sign this authorization. I am aware of my right to receive a copy of this signed authorization.

\*Note: This authorization refers to both internal VCC use as well as external VCC use.

## SIGNATURES

\_\_\_\_\_  
*Signature of Participant*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Printed Name of Participant*

\_\_\_\_\_  
*Signature of Participant's legal representative  
(if the Participant is younger than age 18)*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*If the Participant is below age 18, state a  
description of the legal representative's  
authority to sign for the participant*

\_\_\_\_\_  
*Date of Birth of Participant*

\_\_\_\_\_  
*Primary Phone Number*

\_\_\_\_\_  
*Secondary Phone Number*

\_\_\_\_\_  
*Street  
Mailing Address of Participant*

\_\_\_\_\_  
*City, State, Zip  
Mailing Address of Participant*

## Release of Liability for Transportation

I, \_\_\_\_\_ (Parent/Guardian's Name), as the parent/legal guardian of \_\_\_\_\_ (Student's name), a minor, hereby give permission for said child to participate in any activity sponsored or operated by the Vista Community Clinic (herein after referred to as "VCC"). I further give permission for VCC staff, volunteers, and other agents (collectively hereinafter referred to as VCC's "Personnel") to transport my child so that my child may participate in programs operated or sponsored by VCC. I acknowledge and understand that accidents may occur, and injuries and/or damage to persons and/or property, may result from such. Neither I, nor my child, or anyone else acting on behalf of my child, shall seek to hold VCC or its personnel liable for any accidents, damages, and/or injuries caused, including, but not limited to, the acts of third parties, equipment failure of VCC's Personnel and I agree to hold VCC free and harmless on any claims brought by, or on behalf of myself, my child, or by any third party, arising from my child participating in any program operated by or sponsored by VCC, including transportation to and from that program.

### Medical Authorization

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Further, as said parent/legal guardian of \_\_\_\_\_, I authorize VCC and its personnel to consent to all emergency medical care to be rendered by a duly licensed physician to said child. This care may be given under whatever conditions are necessary to preserve the health and safety of my child. I understand and agree that VCC and its staff are not responsible for paying for any such medical treatment of the child and I agree to hold VCC and its staff free and harmless from any liability or responsibility for any medical treatment provided to my child.

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian's Printed name

\_\_\_\_\_  
Student's Printed Name