Membership Application

Student Info:

Name: _____School: _____Grade_____

Age _____ Birthday _____ Female ☐ Male ☐ Email_____

Home Phone: _____ Cell Phone: _____ ☐ ☐

Address: _____

How is it best to contact you? Please check one or more:

☐ Home Phone ☐ Cell Phone ☐ Texting ☐ Email

What prevention issues and projects are you most interested in?

Please Describe: _____

Are you bilingual? _____ If yes, what languages? _____

Interest and Skills re: prevention advocacy (i.e. social media, film production, data analysis, public speaking, etc.):

_____

Are you interested in working on community substance abuse prevention projects through *Friday Night Live and North Coastal Prevention Youth* Coalition outside of school hours? Yes ☐ No ☐

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

_____

Please briefly tell us why you would like to be a part of FNL and NCPYC:

_____

Parents/Guardian info:

Name: _____ Hm. Phone: _____ Cell Phone_____

Email_____

How is it best to contact your parents? Please check one or more:

☐ Home Phone ☐ Cell Phone ☐ Texting ☐ Email

Vista Community Clinic
North Coastal Prevention Youth Coalition
Permission Slip

Dear Parent/Guardian:

With your permission, your child wishes to participate in the North Coastal Prevention Youth Coalition (NCPYC). This Coalition kicks-off on September 1, 2020 and will continue through August 31, 2021.

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

If you have any questions regarding any of the activities of the Youth Coalition, please contact Erica Leary, Program Manager at 760-631-5000 x 7150 or Carmela Muñoz, Prevention Specialist at x7147.

I give permission for my child _____ to participate in the NCPYC.

_____ _____
Parent/Legal Guardian Signature Date

About North Coastal Prevention Coalition (NCPC)
The North Coastal Prevention Coalition aims to reduce the harm of alcohol, tobacco, marijuana and other drugs in the cities of Carlsbad, Oceanside and Vista through community action, education, support and collaboration. Funded in part by the County of San Diego, HHSA, Behavior Health Services through a contract to Vista Community Clinic.

c/o Vista Community Clinic
1000 Vale Terrace, Vista, CA 92084
760-631-5000 Ext. 7174 Fax 760-414-3736
Website: www.northcostalpreventioncoalition.org Email: info@northcoastalpreventioncoalition.org

Parent Permission for Transportation of Minors

I am the parent/legal guardian of _____, a minor. I hereby give permission for said child to participate in any activity sponsored or operated by the Vista Community Clinic (hereinafter referred to as the "Clinic"). I further give permission for the Clinic staff, volunteers, and other agents (collectively hereinafter referred to as the Clinic's "Personnel") to transport my child so that my child may participate in programs operated or sponsored by the Clinic. I acknowledge and understand that accidents may occur, and injuries and/or damage to person and/or property, may result from such. Neither I, or my child, or anyone else acting on behalf of my child, shall seek to hold the Clinic or its personnel liable for any accidents, damages, and/or injuries caused by, including, but not limited to, the acts of third parties, equipment failure, or the ordinary negligence of the Clinic's personnel. I agree to hold the Clinic 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 the Clinic, including transportation to and from that program.

Further, as said parent/legal guardian, I authorize the Clinic 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 the Clinic and its personnel are not responsible for paying for any such medical treatment of my child and I agree to hold the Clinic and its personnel free and harmless from any liability or responsibility for any medical treatment provided to my child.

The Permission that I have given herein shall cover the period from September 1, 2018 to August 31, 2019.

_____ _____

Parent/ Legal Guardian Signature Date

_____ _____

Parent/Legal Guardian Printed Name Child's printed name

_____ _____

Parent/Legal Guardian Address Telephone number

My child has the following allergies and /or medical conditions: _____

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, program participation and events in promotional, marketing, instructional, or educational projects ("Projects") that show how the programs of the Vista Community Clinic and the North Coastal Prevention Coalition 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 participate in programs, 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.

_____ _____

Youth Participant's Signature Date

_____ _____

Parent/Guardian's Signature Date