Dear Parent/Guardian,

Planned Parenthood Columbia Willamette’s Health Equity Youth Advocates program (HEYA!) prepares young people to partner with doctors, nurses and medical students to effectively talk with youth about their sexual health. HEYA! participants give health care providers feedback through workshops and mock doctor’s visits.

**HEYA! Participants:**
- Construct and lead workshops with health care providers about ways to effectively communicate to young patients about confidentiality, youth rights and their sexual health
- Create a character to use in simulated doctor visits with health care providers to provide feedback on the interaction
- Have opportunities to participate in advocacy efforts
- Have opportunities to learn to use radio and film equipment, explore health issues in a creative way and share their perspectives on the radio, internet and television.

**HEYA! History:**
The HEYA! program was developed by teens in New York City in 2003, and since then, the National Institute's Adolescent Health Care Communication Program has been training teenagers to express their perspectives to providers by giving them a forum to do so. In 2008, the program expanded to Oregon, California, Pennsylvania, Wisconsin and DC. The program in Eugene has had great success in the past six years, and we are pleased that your child is joining the first Portland group.

**Meetings and Presentations:**
HEYA! meetings are every other Tuesday, from 5-7pm at Planned Parenthood's NE location: 3727 NE MLK Jr Blvd. Snacks will be provided. Presentations take place in addition to meetings. Some presentations may take place during school hours. Transportation to presentations will be provided by Planned Parenthood from an arranged meeting point.

As a parent of a HEYA! intern, we welcome your support and input. If you have any questions, please don’t hesitate to be in touch.

Sincerely,

Nili Yosha
Health Equity Youth Advocates Coordinator
503-775-4931 x2537
nili.yosha@ppcw.org

I you are under 18, your parent/guardian’s consent is necessary for us to process the application. Please fill out this packet and return the original hardcopy.

My child ______________________ has my permission to participate in the Health Equity Youth Advocates Program sponsored by Planned Parenthood Columbia Willamette.

Signature of Parent/Guardian: ___________________________ Date: ____________________
(“Parent” is defined to mean one or both parents living in a Teen’s household or, if parent(s) are not available because of permanent separation from the Teen, is the person legally acting in full capacity of parent.)
Name

Address

City/State/Zip

Phone – Can you send or receive text messages? □ Yes □ No

Email

Parent/Guardian name(s) and relationship to you (father, mother, stepfather, stepmother, etc.)

Languages spoken at home

School/Grade you will be in next year

Current age/Birthday

Gender: ________________________________

Race/Ethnicity:

□ African  □ African-American  □ Asian
□ White  □ Latinx/Latina/Latino  □ Multi-racial
□ Native American  □ Other  □ Pacific Islander

Preferred Pronoun:

□ She/her  □ Him/his  □ They/their  □ Ze/hir  □ Other: ___________________
# Consent Form

## General Medical Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Date _____________________________________________________________________</td>
</tr>
<tr>
<td>Participant Name</td>
<td>_________________________________________________________________________</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>_________________________________________________________________________</td>
</tr>
<tr>
<td>Age</td>
<td>_________________________________________________________________________</td>
</tr>
<tr>
<td>Parent/Guardian Name(s)</td>
<td>_________________________________________________________________________</td>
</tr>
<tr>
<td>Address</td>
<td>_________________________________________________________________________</td>
</tr>
<tr>
<td>City</td>
<td>__________________________ State __________________________ Zip ____________</td>
</tr>
<tr>
<td>Phone #</td>
<td>__________________________ Alt. Phone # ___________________________________________________________________________________</td>
</tr>
<tr>
<td>Other Contact</td>
<td>__________________________ Phone # __________ Alt. Phone # __________________________________________________________________</td>
</tr>
<tr>
<td>Doctor Name / Address</td>
<td>_________________________________________________________________________</td>
</tr>
<tr>
<td>Phone #</td>
<td>_________________________________________________________________________</td>
</tr>
<tr>
<td>Hospital</td>
<td>__________________________ Phone Number __________________________________________________________________________________</td>
</tr>
</tbody>
</table>

## CHECK OR FILL IN BLANKS TO ALL THAT APPLY

Does the participant have health insurance?  
- [ ] Yes  
- [ ] No

If yes, please complete health insurance information below:

- Insurance Name: ___________________________  
- Group Number: ___________________________  
- ID number: ___________________________

Is the participant allergic to any medication or products?  
- [ ] Yes  
- [ ] No

If so, what? ___________________________  
Reaction: ___________________________

Is the participant allergic to insect bites?  
- [ ] Yes  
- [ ] No

If so, do they have an insect bite kit for emergencies?  
- [ ] Yes  
- [ ] No

If so, where does the participant keep the kit? ___________________________

When did the participant receive their last Tetanus vaccination? ___________________________
Consent Form
General Medical Information
(Continued)

Does the participant have asthma? □ Yes □ No
If so, where does the participant keep inhaler? ________________________________________

Does the participant have food or medication allergies? □ Yes □ No
If so, please specify: ______________________________________________________________

Does the participant take medications? □ Yes □ No

<table>
<thead>
<tr>
<th>If yes, current medications (prescription and over-the-counter)</th>
<th>Dose &amp; schedule</th>
</tr>
</thead>
</table>

PLEASE BE SURE THAT MEDICATIONS ARE IN LABELED CONTAINERS.

My child has my permission to keep medications listed above in his/her possession and take them independently □ Yes □ No □ N/A

Planned Parenthood has permission to provide over-the-counter medications to the participant for the relief of minor pain or insect bites (i.e., Ibuprofen, Tylenol, Benadryl, hydrocortisone cream) □ Yes □ No

Does the participant have any conditions that would keep them from participating in group activities requiring moderate physical activity? □ Yes □ No
If so, please specify: ________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

As parent/guardian, I hereby give permission, in case of accident and/or emergency, to PPCW staff to seek medical attention for my son/daughter. I also give permission to the physician to hospitalize, secure treatment for and to order injection, anesthesia, or surgery for my son/daughter, as named above, according to the medical standards and expertise then and there available, whether known or unknown. (A parent will be contacted first, whenever possible).

Parent Signature: ___________________________________________ Date: ____________________________

Signature of HEYA participant: ___________________________________________ Date: ________________
Occasionally Planned Parenthood’s education programs are featured for the excellent work the young peer educators are doing. This could include participating in promotional events, news articles, yearbook photos, etc.

By signing this form, you consent to be photographed, filmed, videotaped or recorded, and authorize Planned Parenthood Federation of America and all other Planned Parenthood organizations (collectively, “Planned Parenthood”), their authorized representatives and Nili Yosha to use the following materials:

- Still photographs
- Videotapes and / or films
- Audio tape (voice) recordings
- Peer Educator’s name

The above materials may be used in:

- Planned Parenthood’s education, fundraising, and promotional programs
- Planned Parenthood’s brochures, newsletters and publications
- Planned Parenthood’s websites and other social networking sites
- Publicity & press materials
- Grant reports
- Community radio and community access television

Name of HEYA participant: ________________________________________________________________

Signature: ___________________________ Date: ___________________________

Name of Parent/Guardian of HEYA participant: ____________________________________________

Signature: ___________________________ Date: ___________________________
I understand that my child is participating in the Planned Parenthood Columbia Willamette's Health Equity Youth Advocates Program. They are responsible for their own transportation to meetings and events during the program year. However, I also agree that my child may, on occasion, need to be transported by the program coordinator or a responsible adult assisting with the program to community events, or program activities. Therefore, I hereby give my permission to have my child transported for these such purposes.

Signature: ___________________________________________ Date: _______________________
(PARENT OR GUARDIAN)

Signature: ___________________________________________ Date: _______________________
(PARTICIPANT IF OVER 18)

Name: __________________________________________________________________________

☐ Yes/☐ No I have a valid driver’s license. State:_______ License No:__________ Exp. Date:_______

☐ Yes/☐ No I carry minimum auto liability limits as required by Oregon and/or Washington State of $25,000 per occurrence and $50,000 aggregate combined single limit of liability and $10,000 property damage. Oregon drivers must also carry Personal Injury Protection and Underinsured Motorist coverage.

Company:_________________________ Policy Number:_________________________

☐ Yes/☐ No I agree to maintain a current Oregon or Washington state driver's license and at least the minimum insurance required by state law for the duration of my involvement in the Teen Council.

☐ Yes/☐ No I have been informed and understand that my insurance is the primary insurance covering my vehicle when on Planned Parenthood Columbia Willamette (PPCW) Teen Council business. This business does not include transportation to and from meetings and events because this is considered commuting. I understand that while commuting, PPCW does not provide automobile insurance coverage and agency will not be liable for damages should an accident occur. In the event I am driving between locations and PPCW-sponsored events, I understand that this is considered driving on PPCW business and my insurance is the primary insurance covering my vehicle.

Signature: ___________________________________________ Date: _______________________

Consent Form
Travel Consent Form & Vehicle Operation Liability Form