

REALITY CHECK

Hooray! Your child has decided they would like to be a part of **Reality Check** of Jefferson, Lewis and St. Lawrence Counties. **Reality Check** is a youth led, adult supervised, program dedicated to exposing the manipulative and deceptive marketing tactics of the tobacco industry. Youth from across the state work to produce change in their communities through grassroots mobilization and education while empowering youth to see that they are more than just *Replacement Smokers* for the tobacco industry and that they can become leaders in their community.

Throughout the year **Reality Check** will be participating in various community events including parades, tabling events, health fairs, tobacco audits, a statewide youth summit and a Legislative Day in Albany.

Legislative Day is a day dedicated to educating our state legislatures on our program initiatives and updating them on our program activities. **Reality Check** youth travel to Albany to advocate for the program and participate in youth activism workshops with other **Reality Check** youth from across the state.



Youth Summit is a two-day retreat where **Reality Check** youth from across the state join together to participate in training workshops and fun activities to fight back against the tobacco companies. Youth from across the state work together to create events, activities and ideas that will be used throughout the year for tobacco action days.

This permission slip allows your child to participate in all **Reality Check** events throughout the school year. By signing this permission slip for your child, you are allowing them **to travel in vehicles with**

Program Coordinators and **attend events outside of the area**. Some events may include limited overnight travel. As a parent/legal guardian you will receive additional notice before your child participates in such events.

This permission slip also allows Program Coordinators to administer emergency CPR/First Aid if necessary. Please be sure to provide any information regarding your child's allergies and health information.

Finally, this permission slip also serves as a photo release. Throughout the year, Program Coordinators will take photos of your child in action at **Reality Check** events. Some of the photos that staff take may be posted on social media sites, **Reality Check** websites or distributed to local media outlets.



Youth Information

Name:	
Age:	
Date of Birth (mm/dd/yyyy):	
Gender:	
Home Phone Number:	
Cellphone Number:	
<i>Is the cellphone a smart device?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Address:	
Email:	
T-Shirt Size (adult):	
School:	
Grade Level:	

Parent/Guardian Information (No.1)

Name:	
Relationship to Youth:	
Home Phone Number:	
Work Phone Number:	
Cell Phone Number:	
Preferred Form of Contact:	<input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Cell Phone

Parent/Guardian Information (No.2)

Name:	
Relationship to Youth:	
Home Phone Number:	
Work Phone Number:	
Cell Phone Number:	
Preferred Form of Contact:	<input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Cell Phone

I, _____ (parent/guardian name), give my permission for my child,
 _____ (youth name), to participate in **Reality Check**.

I understand the following:

Trainings are designed to educate and update the New York State advocates on the latest techniques in tobacco prevention.

I agree that no Program Coordinator associated with **Reality Check** will be held responsible for any injuries or damages that occur while my child is traveling to, from, or participating in a training or event.

I permit my child to travel in vehicles with Program Coordinators to participate in events.

I grant permission for my child to appear in person or in voice, video, or photographic presentation for radio, television, websites, social media, or print media reports and/or media campaign(s) resulting from participation in **Reality Check** events.

I permit my child to complete confidential or anonymous surveys and participate in interviews for evaluation purposes.

I grant permission for the Program coordinator to access **Reality Check** participants school email in order to notify students of meeting times and cancellations

I grant my child permission to download the "BAND" app for my child to communicate with the Program coordinator and other Reality Check youth.

Legal Guardian Signature: _____ Date: _____

Reality Check Youth Signature: _____ Date: _____

Youth Code of Conduct

REALITY CHECK TRAININGS, MEETINGS & EVENTS

The following code of conduct will be enforced at every youth training, meeting, and event that is held for **Reality Check**. **All participants and their parent or guardian must sign this document before the youth can participate in any events.**

1. The possession and/or use of weapons, alcoholic beverages, tobacco products, and illegal drugs, or remaining in the presence of individuals who are using or taking these items is prohibited.
2. Any sexual contact, which occurs within the timeframe of **Reality Check** youth trainings, meetings, or other sponsored events, is prohibited. This includes, but is not limited to, dance moves that are sexual in nature. This is at the discretion of any Coordinator or other adult supervisor/chaperone. A warning will be given.
3. **Dress code:** May vary depending on the nature of the event, please check with your Coordinator for special situations such as legislative visits, public hearings, and professional meetings. Undergarments, body parts that are considered private, and your chest should not be showing. These areas of your body should be fully covered. Shorts or skirts must exceed your arms' length when fully extended. You will be asked to change, or unable to participate in an event, if you do not adhere to these guidelines.
4. **Overnight travel:** Entering the lodging room and/or lodging floor, dorm, or sleeping space of the opposite gender is prohibited for the duration of **Reality Check** events. This includes free time and any time before or after curfew. All participants **must adhere to the curfew** and will be in their assigned rooms/space by the set curfew.
5. **Events:** All participants are to remain on the grounds, in the buildings, and in other approved designated areas for the duration of all **Reality Check** events. Program Coordinators must be aware of the location of youth at all times. Participants must show respect for the property of others and the facility in which the event is being held. **Attendance and punctuality of scheduled trainings/meetings is considered mandatory by all participants.**
6. Any behavior that violates any of the laws of the United States or the State of New York or any local ordinance is prohibited.

By signing below, I acknowledge that I have read the above code of conduct. Both parent/guardian and youth understand that if it is determined that the youth has/have violated the code the parent/guardian will be called to pick their child(ren) up or provide transportation home for the youth at their expense and said youth will no longer be able to attend overnight events for **Reality Check**. The responsibility for making this determination is vested in the Program Coordinators.

Participant's Signature: _____

Date: _____

Parent or Guardian's Signature: _____

Date: _____

Medical Release Form

On rare occasions, an emergency requiring hospitalization and/or surgery develops. As a general rule, anesthesia may not be administered to or operation performed without written permission by the parents or legal guardians. Therefore, to prevent a dangerous delay, if an emergency does occur and we are unable to contact the parents or legal guardian, the parent/guardian is asked to sign the release form below.

Medical Information	
Youth Name:	
Date of Birth (mm/dd/yyyy):	
Is the minor listed above allergic to any medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If your child is allergic to medications, please list:</i>	
Please list any medical conditions of which staff should be aware:	
Please indicate any special needs or disabilities that program staff should know about.	
Please indicate any special dietary restrictions such as vegetarian or food allergies	
Insurance Company:	
Insurance Policy #:	

Note: Medications will be held by the Program Coordinators. Medications must be in original containers and have the youth's name and dosing instructions clearly identifiable on the label – this includes prescribed as well as over-the-counter medications.

Please identify special limits to treatment, if any:

Emergency Contact Information

Name of Emergency Contact:	
Relationship to Youth:	
Home Phone Number:	
Work Phone Number:	
Cell Phone Number:	
Preferred Form of Contact:	<input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Cell Phone

I, _____ (legal guardian name), authorize that all the above information is accurate and up to date to the best of my knowledge. I understand the importance of providing any allergies that my child has for their safety while with the Program Coordinators.

I hereby authorize Program Coordinators to secure whatever treatment is deemed necessary and, if recommended by an attending physician, the administration of an anesthetic or surgery.

Parent or Guardian's Signature: _____

Date: _____

