



PROGRAM PARTICIPATION CONSENT FORM AND APPROVAL BY PARENT OR LEGAL GUARDIAN

Student's full name: _____

AGREEMENT

I understand that involvement in the **Nursing CAP, Inc.** program requires the program participant to attend and actively participate in the program. I have carefully considered the commitment of the program from September 20__ – July 20__ and have given consent for my child to participate in this program. I also understand that participation in this activity is entirely voluntary and requires participants to abide by applicable rules and standards of conduct. I release the Nursing CAP executive director and all employees, volunteers, related parties, or other organizations associated with the activities from any and all claims or liability arising out of this participation.

I understand that, in the event medical treatment is required, every effort will be made to contact me. However, if I cannot be reached, I consent to and authorize the giving of all medical treatments, medications and the performance of any technical procedures, which are ordered by a physician for the care of the above named student. I agree to the release of any records necessary for treatment, referral, or billing. I understand that Nursing CAP, Inc. or the chaperones are not responsible for the quality of any such medical treatment. I also agree to accept all financial responsibilities incurred as a result thereof.

Please print the information below:

Parent/Guardian Name

Home phone

Cell Phone

Email Address



Emergency Information:

Emergency Contact and Relationship to Child

Address

City

State

Zip Code

Telephone (Home)

(Cell)

(Work)

Email Address

Family Physician

Phone

Allergies (foods, medications, and other)

Current Medications

My child is under the care of a physician for the following condition(s):

Date of last Tetanus Immunization

Family Health Insurance Information:

Carrier and Carrier Address

Group #

Insured and student's relationship to insured

Policy #

Signatures:

Signature of Parent/Guardian

Date

Signature of Student

Date

Electronic Signature Agreement: By typing your name, you are signing this document electronically. You agree your typed signature is the legal equivalent of your manual signature on this document.



Date: _____

NURSING CAREERS AND PATHWAYS STUDENT BACKGROUND INFORMATION

(Please Type or Print)

Student Information

Name

Address

City

State

Zip Code

Telephone: (Home)

Telephone:(Cell)

Email Address

What is your gender? ☐ Male ☐ Female

What is your date of birth?

Month _____ Day _____ Year _____

High School Graduation Month and Year: _____

What grade are you in school this year?

- | | | | |
|------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| ☐ 5th grade | ☐ 6th grade | ☐ 7th grade | ☐ 8th grade |
| ☐ 9th grade | ☐ 10th grade | ☐ 11th grade | ☐ 12th grade |

What is your race or ethnicity?

- | | | |
|--|--|---|
| ☐ Black or African-American | ☐ Asian or Pacific Islander | ☐ Native American / Alaskan Native |
| ☐ White, non-Hispanic | ☐ Multi-ethnic | ☐ I prefer not to answer |
| ☐ Hispanic / Latino | ☐ Other | |

What school do you attend? _____

Are you eligible for free or reduced price lunch at school? ☐ Yes ☐ No



What are your current classes?

Class	Class

Here are some things young people do...if possible, please have student to complete these questions.

Please select either **Yes** or **No**. If the answer to a question is yes, please answer how many.

Example: if you were suspended from school twice last year, select **Yes** and type **2** for "How many times?".

During the last school year, did you...

	Yes	No	If yes, how many times?
Get on the honor roll?			
Get an "A" on your report card in <i>math</i> ?			
Fail any courses for the whole year?			
Get any failing grades on your report card?			
Get suspended from school?			
Cut classes without permission?			

Please give us the names of two adults who would always know how to contact you. At least one of these adults should be your parent or guardian.

First and Last Name	Relationship to you	Phone number(s)
		Home: (____) ____ - ____ Cell: (____) ____ - ____
		Home: (____) ____ - ____ Cell: (____) ____ - ____



Please give us the names of two other people who would always know how to contact you.

First and Last Name	Relationship to you	Phone number(s)
		Home: (____) ____ - ____ Cell: (____) ____ - ____
		Home: (____) ____ - ____ Cell: (____) ____ - ____

Please tell us how to reach you on social media:

Facebook Name: _____

Twitter Handle: @ _____

Other Site/App: _____ Username/Handle: _____

****Please attach your final report card for the last academic year (Required for ALL Participants.)**

****Write two developed paragraphs stating “Why I want to become part of the Nursing Careers and Pathways Program?” (NEW STUDENTS ONLY)**



PUBLICATION CONSENT FORM

NURSING CAREERS AND PATHWAYS PROGRAM

I consent to the use of my child's photograph, video, and/or voice recording by Nursing CAP, Inc. for the purpose of promoting the program. This includes television, print media, Nursing CAP publications, and monitored social media websites by the Board of Directors such as Facebook, Twitter, YouTube, Instagram and www.nursingcap.org. The photographs, videos, recordings, and publications will be the property of Nursing CAP, Inc. and Nursing CAP, Inc. shall have the right to sell, duplicate and reproduce articles free and clear of any claim whatsoever on my part.

Student Information

Name

Address

City

State

Zip Code

Parent/Guardian Information

Name

Address

City

State

Zip Code

Telephone: (Home)

Telephone:(Cell)

Signature of Parent/Guardian

Date

Electronic Signature Agreement: By typing your name, you are signing this document electronically. You agree your typed signature is the legal equivalent of your manual signature on this document.



NURSING CAREERS AND PATHWAYS (Nursing C.A.P.) PROGRAM

STUDENT Rules and Expectations:

1. The Nursing C.A.P. program expects your child will conduct himself/herself in an appropriate manner at all times in the hospital and healthcare facilities.
2. Your child will use appropriate language and subject matter at the program sessions and field trips (profanity, or abusive language are prohibited).
3. Students shall have respect towards themselves, volunteers and other students in the program. Fighting, bullying and harassment are prohibited.
4. The students will obey the directions of program director and adult volunteers.
5. Students must be accompanied by an adult/volunteer at all times while in Sentara Obici Hospital.
6. Students must attend at least 70% of the sessions to attend the end-of-year celebration.
 - Students/Parents should notify Program Director of any absences from the program by phone, text, or e-mail.
 - **Students will receive 1/2 (half) credit for any excused absences and WILL NOT receive credit for unexcused absences.**
 - **Students will receive 1/2 (half) credit leaving before 11:30 a.m. from a session. - NEW**
 - Unexcused absences may affect the student's ability to participate in the end-of-year celebration.
 - **Keep in mind the students with the least excused absences are eligible for the highest awards at the end-of-year celebration.**
 - This policy is not intended to punish students. Rather it is intended to teach the students the importance of developing good character in school, church and the community.
7. Electronic devices will not be permitted during the guest presentations unless authorized by program director or adult volunteers.
8. The students will maintain proper dress attire and grooming for all sessions and field trips.
9. The students will not damage or destroy property belonging to others or the healthcare facilities.
10. All trash must be disposed of in proper receptacle, before leaving healthcare facilities.



Levels of Disciplinary Actions:

1. Verbal Warning to student and parent.
2. Conference with the student and parent.
3. Intervention:

Student behavioral contract – The student/parent/guardian must compose a written agreement between program director on areas for improvement in child's conduct and set goals for correcting behavior.

4. Suspension from program for **two** sessions.
5. Expulsion from the Nursing C.A.P. program.

We have read and we understand the above expectations.

Signature of Parent/Guardian

Date

Signature of Youth

Date

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Video Conferencing Student Guidelines NURSING CAREERS AND PATHWAYS PROGRAM

1. Be on time.
2. Check sound and video before the session starts.
3. Come prepared bring pencils, paper, schoolwork, and textbooks.
4. Be respectful when listening, speaking, and writing in the chat box.
5. Keep your sound on mute until you are asked to speak.
6. Raise your virtual hand to participate.
7. Keep your video on at all times and turn your video off when you need to take a break and leave the room.
8. Stay in one place with minimal distraction.
9. Do not take pictures or videos of the meeting.
10. Use a simple background.
11. Have an adult within earshot.
12. Be dressed and groomed in the appropriate matter.

I consent for my child to participate in these distance-based, virtual programming with Nursing CAP, Inc. I understand that Nursing CAP, Inc. will be using software, tools, and applications provided by Zoom. I recognize that Zoom is a third party company. I understand my child's image may be transmitted during video portions of these sessions. We have read the Zoom Video Communications, Inc. Legal and Privacy terms and the guidelines above and we understand. <https://zoom.us/privacy-and-legal>

Signature of Parent/Guardian

Date

Signature of Youth

Date

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Confirmation of Email Opt-In NURSING CAREERS AND PATHWAYS PROGRAM

As a participant in Nursing Careers and Pathways, you will get messages about announcements, important dates, and events on a regular basis. By signing below, you are agreeing to receive messages from our email addresses (info@nursingcap.org, rmckinneycrna@gmail.com, regina.mckinney@nursingcap.org and from other program leaders, volunteers, or staff periodically. Please whitelist or add these email addresses to your contacts to ensure our messages appear in your inbox.

We will protect your email address and any personal information you provide by storing it safely in our records. We will not sell or distribute your information to any third parties. You can unsubscribe at any time by clicking unsubscribe at the bottom of the message you receive. For more information please contact us at info@nursingcap.org.

Print Full Name of Parent/Guardian

Date

Signature of Youth/Guardian

Date

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NURSING CAREERS AND PATHWAYS

PARENTAL PERMISSION for Mental Health Wellness Sessions with licensed mental health professionals

I _____ certify that I am the parent, guardian, or
Print name of parent, guardian, or custodian

custodian of _____. I authorize and consent for my
Print name of participant

child to participate in these mental health sessions with Nursing CAP, Inc. I also understand that participation in these sessions and activities is entirely voluntary and requires participants to abide by applicable rules and standards of conduct outlined on the Video Conferencing Student Guidelines. I release the Nursing CAP executive director and all employees, volunteers, related parties, or other organizations associated with these sessions and activities from any and all claims or liability arising out of this participation.

We have read and we understand the above consent.

Signature of Parent/Guardian

Date

Signature of Youth

Date

Electronic Signature Agreement: By typing your name, you are signing this document electronically. You agree your typed signature is the legal equivalent of your manual signature on this document.