UC DAVIS HEALTH | SCHOOL OF MEDICINE

# Health Equity Academy – Leaders for Tomorrow's Healthcare (HEALTH)

# Program Application – Spring 2020

**Parent & Student Orientation**| Date: 2/25/20 Time: 5:30pm - 7:00pm
**Program Sessions** | Date: 2/29/20, 3/7/20, 3/21/20, 4/4/20, 4/18/20, 4/25/20 Time: 9:00am - 3:00pm

**ATTENDANCE IS REQUIRED FOR ALL SESSIONS**

**Directions:** Please complete the application in its entirety using a black or blue pen. Ensure that your writing is legible, especially email and phone numbers.
Incomplete or late applications **will not** be considered. **Application deadline is February 7, 2020 by 5:00pm.**

| **APPLICANT INFORMATION** | | | | | |
|---|---|---|---|---|---|
| First Name | | Last Name | | Middle Initial | |
| Street Address | | | | Apartment/Unit # | |
| City | | State | | ZIP | |
| Phone | | E-mail Address | | | |
| Date of Birth | | School | | Grade Level | |

| **GENDER INFORMATION** | | | | | |
|---|---|---|---|---|---|
| How do you identify? (check any that apply) | | | | | |
| Male | ☐ | Non-binary/ third gender | ☐ | Prefer not to say | ☐ |
| Female | ☐ | Transgender | ☐ | Prefer to self-describe: | ☐ |

| **PARENT/GUARDIAN/EMERGENCY INFORMATION** | | | | | |
|---|---|---|---|---|---|
| Parent/ Guardian Name | | Phone | | Relationship to Applicant | |
| Parent/Guardian Highest Education Level Completed | None ☐ | Middle School ☐ | High School ☐ | Community college ☐ | 4yr university ☐ |
| Parent/ Guardian Name | | Phone | | Relationship to Applicant | |
| Parent/Guardian Highest Education Level Completed | None ☐ | Middle School ☐ | High School ☐ | Community college ☐ | 4yr university ☐ |
| Emergency Contact Name | | Phone | | Relationship to Applicant | |

| Does the parent/guardian and the applicant receive any of the following support? (check any that apply) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Free Reduced School Lunch | ☐ | Medi-Cal | ☐ | Pell Grant | ☐ | Section 8 Housing | ☐ |
| SNAP/WIC | ☐ | Supplemental Security Income | ☐ | Welfare/TANF | ☐ | None | ☐ |

| ETHNIC BACKGROUND | | | | | | | |
|---|---|---|---|---|---|---|---|
| How do you identify in terms of race and ethnicity? (check any that apply) | | | | | | | |
| American Indian/Alaska Native | ☐ | East Indian/Pakistani | ☐ | Mexican | ☐ | Vietnamese | ☐ |
| Black/African American | ☐ | Filipino | ☐ | Middle Eastern | ☐ | White/Caucasian | ☐ |
| Cambodian | ☐ | Hmong | ☐ | Native Hawaiian/Pacific Islander | ☐ | Other: | ☐ |
| Chinese | ☐ | Latino/Hispanic | ☐ | Ukrainian | ☐ | | |

| PROGRAM INVOLVEMENT | | | | | | | |
|---|---|---|---|---|---|---|---|
| Are you currently enrolled in any of the programs listed below? (check any that apply) | | | | | | | |
| AVID | ☐ | GEAR UP | ☐ | SMASH | ☐ | Yes2Kollege | ☐ |
| Decision Medicine | ☐ | KP Launch | ☐ | TRIO Talent Search | ☐ | Youth Development Network | ☐ |
| Early Academic Outreach Program | ☐ | MESA | ☐ | TRIO Upward Bound | ☐ | None | ☐ |

| DIETARY RESTRICTIONS |
|---|
| Do you have any dietary restrictions (i.e. vegetarian, gluten, etc.)? |
| |

| MEDICAL INFORMATION |
|---|
| Please describe any Allergies or Health Conditions we need to be aware of. |
| |

| AMERICAN DISABILITY ACT ACCOMMODATIONS |
|---|
| Please describe any ADA accommodations you will need to participate in this program. |
| |

| QUESTIONAIRE |
|---|
| Please answer the following questions in a paragraph format. All responses should be legible. |

1. In your own words what does “community health” mean to you?

2. Why do you want to participate in this HEALTH program?

3. What do you hope to gain from this HEALTH program?

**INTEREST**

Which if any health professions are you interested in? (check any that apply)

| | |
|---|---|
| ☐ | DDS or DDM Doctor of Dental Surgery or Doctor of Dental Medicine |
| ☐ | Dental Assistant or Hygienist |
| ☐ | Phlebotomist |
| ☐ | PA or Physician Assistant |
| ☐ | FNP or Family Nurse Practitioner |
| ☐ | RN or Registered Nurse |
| ☐ | Social Worker or Counselor |
| ☐ | MA or Medical Assistant |
| ☐ | MD or Doctor of Medicine |
| ☐ | Physical or Occupational Therapist |
| ☐ | Ultrasound or X-Ray Technician |
| ☐ | Other (Please Indicate): |

**LIST YOUR TEAM OF 4-6 STUDENTS (GRADES 9-12)**
**MINIMUM OF 4 PER TEAM (REQUIRED)**
**MAXIMUM OF 6 PER TEAM**

**Each team member/applicant must complete and submit an individual application.**

**TEAM MEMBER LIST**
*Include yourself below*

| | First and Last Name | Phone Number | Current School and Grade Level |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |

**STATEMENT OF AGREEMENT AND SIGNATURES**

Please initial below if you agree with the following statements:
____ I certify that my answers are true and complete.
____ I acknowledge that I will be held responsible and accountable for all my actions throughout the Health Equity Academy.
____ I will abide by all program rules and be respectful to everyone at the Health Equity Academy.
____ I will commit to actively participate and attend orientation and all program sessions.
____ I understand that Risk/Liability, Medical, and Media Waivers will need to be completed prior to the start of Health Equity Academy.

Student Signature: Date

Parent/Guardian Signature: Date

Participant's Name: _____

Please Print

UNIVERSITY OF CALIFORNIA, Davis
UC Davis School of Medicine, Office of Student and Resident Diversity

## Waiver of Liability, Assumption of Risk, and Indemnity Agreement

**Waiver**: In consideration of being permitted to participate in any way in UC Davis School of Medicine - Spring 2020 Health Equity Academy - Leaders for Tomorrow's Healthcare

Hereinafter called "Activity", I, for myself, my heirs, personal representatives or assigns, **do hereby release, waive, discharge, and covenant not to sue** The Regents of the University of California, its officers, employees, and agents from liability **from any and all claims** resulting in personal injury, accidents or illnesses (including death), and property loss arising from, but not limited to, participation in Activity.

_____ _____

Signature of Parent of Minor Date Signature of Participant Date

**Assumption of Risks:** Participation in Activity carries with it certain inherent risks that cannot be eliminated regardless of the care taken to avoid injuries. The specific risks vary from one activity to another, but the risks range from 1) minor injuries such as scratches, bruises, and sprains to 2) major injuries such as eye injury or loss of sight, joint or back injuries, heart attacks, and concussions to 3) catastrophic injuries including paralysis and death.

**I have read the previous paragraphs and I know, understand, and appreciate these and other risks that are inherent** in Activity I hereby **assert that my participation is voluntary and that I knowingly assume all such risks.**

**Indemnification and Hold Harmless:** I also agree to INDEMNIFY AND HOLD The Regents of the University of California HARMLESS from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney's fees brought as a result of my involvement in Activity and to reimburse them for any such expenses incurred.

**Severability:** The undersigned further expressly agrees that the foregoing waiver and assumption of risks agreement is intended to be as broad and inclusive as is permitted by the law of the State of California and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

**Acknowledgment of Understanding:** I have read this waiver of liability, assumption of risk, and indemnity agreement, fully understand its terms, and **understand that I am giving up substantial rights, including my right to sue**. I acknowledge that I am signing the agreement freely and voluntarily, and **intend by my signature to be a complete and unconditional release of all liability** to the greatest extent allowed by law.

_____ _____

Signature of Parent of Minor Date Signature of Participant Date

Participant's Age (if minor) _____

# UC DAVIS SCHOOL OF MEDICINE
## Health Equity Academy – Leaders for Tomorrow's Healthcare
## *Medical Information & Authorization Form*

**PROGRAM DATES: February 29, 2020 – April 25, 2020**

## STUDENT INFORMATION

**STUDENT NAME:** _____ **SCHOOL:** _____

**MEDICAL INSURANCE CARRIER:** _____ **POLICY NUMBER:** _____

**DATE OF BIRTH:** _____ ☐ **MALE** ☐ **FEMALE**

**ALL MEDICAL ALLERGIES:** _____

**ALL MEDICAL CONDITIONS:** _____

**ALL MEDICATIONS STUDENT IS CURRENTLY TAKING:** _____

**SPECIAL INSTRUCTIONS:** _____

_____

_____

**In the event of emergencies, the following over-the-counter medications may be given (check any that apply):**

☐ **Ibuprofen** ☐ **Benadryl** ☐ **Aspirin** ☐ **Tylenol** ☐ **Acetaminophen** ☐ **Aleve**

## EMERGENCY CONTACT INFORMATION

**NAME:** _____ **RELATIONSHIP TO STUDENT:** _____

**HOME PHONE #:** _____ **CELL PHONE #:** _____

## MEDICAL AUTHORIZATION

**In the event of illness or injury, I do hereby consent to whatever x-ray, examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care are considered necessary in the best judgment of the attending physician, surgeon or dentist and performed by or under the supervision of a member of the medical staff of the hospital or facility furnishing medical or dental services. I understand that UC Davis School of Medicine does not provide any medical insurance or cover any charges my student may incur due to injury or illness during this activity.**

_____ _____ _____

**Parent/Guardian Print Name** **Parent/Guardian Signature** **Date**

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## *Media Reproduction Waiver*

*This waiver allows the **UC Davis School of Medicine** staff and or students to reproduce photographs/videos of your child, survey results, and written materials, without any obligation or compensation.*

I hereby waive the right to receive any payment for signing this release and waive the right to receive any payment for the **University of California, Davis – School of Medicine** to use of any of the material described above for any of the purposes authorized by this release. I also waive any right to inspect or approve finished photographs, audio, video or multimedia images and or documents.

I acknowledge that I have read the foregoing and I fully understand the contents.

_____

Student Name

_____

Parent Name

_____

Parent Signature Date

| DOCUMENT CHECKLIST | |
|---|---|
| ☐ | HEALTH Academy Program Application – Spring 2020 |
| ☐ | Risk and Liability Waiver |
| ☐ | Medical Authorization Form |
| ☐ | Media Waiver |

**SUBMIT COMPLETED APPLICATION WITH DOCUMENTS**

**PREFFERED METHOD:**

- Scan and email to larlee@ucdavis.edu or fax to 916-703-5568

OR

**MAIL HARD COPY TO:**

- UCD School of Medicine
  Office of Student and Resident Diversity
  Attn: Health Equity Academy
  4610 X Street, Suite 4101 Sacramento CA
  95817

**Application deadline:**
**February 7, 2020 by 5:00pm.**
**Late applications will not be considered.**