What if your voice could make a difference in your community?

Well, we believe it can!

**uVoice is looking for high school students to join our 2017 – 2018 board!**

**What is uVoice?:**

* A group of teens who **identify** health related issues important to youth, **find solutions** to address needs, and **take action** by granting money to support organizations within Polk County.
* uVoice is a partnership between Community Youth Concepts and the Mid-Iowa Health Foundation.

**As a member of uVoice, YOU will:**

* Gain **LEADERSHIP** skills, **VOICE YOUR OPINION**, and help **CHANGE** issues important to you.
* Build relationships with teens from across Des Moines.
* Take action by designing projects that will impact your community.
* Connect with community leaders and voice your opinion on issues important to you.
* Gain skills that look great on resumes and job applications.
* Earn service hours.

**Membership Requirements:**

* Be a 9th, 10th, 11, or 12th grader during the 2017-2018 school year.
* Attend 2 meetings each month between September - May.
* Attend our kick-off retreat on a Saturday in September.

**How to Apply:**

* Complete and return the following application:
  + Email the completed application to Alicia at alicia@cyconcepts.org
  + Deliver or mail the completed application to:

Community Youth Concepts

Attn. Alicia Vermeer

1446 Martin Luther King Jr. Pkwy

Des Moines, IA 50314

***Questions? Contact Alicia at 515-243-4292 or*** alicia@cyconcepts.org

***Thank you!***

**Confidentiality:** Any confidential information requested is for our records. Your answers will be kept secure and will not be shared with another party. Your cooperation in providing this information is both appreciated and necessary.

**YOUTH INFORMATION**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender \_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_

Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student ID Number ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_\_\_\_\_

CYC Program(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please circle all that apply.*

**Ethnicity:**  Black/African-American  **Household type:** Family

White Family Foster Care

Hispanic/Latino Group Home/Residential

Asian Independent Living Foster Care

African Kinship Care/Extended Family

American Indian

Pacific Islander/ Hawaiian

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I will get home from programming by:** Parent/Guardian Pick up School Bus Walk Drive

**HEAD OF HOUSEHOLD INFORMATION**

Parent/Guardian Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Type  *Home Work*

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Type  *Home Work*

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I would **not** like to receive Newsletters from Community Youth Concepts. Otherwise I will be automatically subscribed to CYC’s Monthly Newsletter.

**EMERGENCY CONTACT AND/OR PICK UP INFORMATION**

***Please list two people (not parents or guardians) who may be contacted in the case of an emergency.***

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If someone not listed is to pick up youth, parents must call to authorize.*

**EMERGENCY MEDICAL INFORMATION**

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Policy Information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Considerations/Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Hospital \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dentist’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATION**

🞎 This student will not take any daily medications while attending programming.

🞎 This student will take the following daily medication(s) while attending programming

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Medication | Reason for taking it | When it is given | Dosage |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

The following non-prescription medications may be stocked at programming facilities and are used on an as needed basis to manage illness and injury. **Cross out those the student should not be given.**

Acetaminophen (Tylenol) Ibuprofen (Advil, Motrin)

Diphenhydramine antihistamine/allergy medicine (Benadryl) Sunscreen

Generic cough drops Antibiotic Cream (Neosporin)

Circle any of the following situations that apply to your youth:

Qualifies for free or reduced school lunch Living with a disability

Completing Court ordered service or former juvenile offender In or aging out of foster care

At risk to leave high school without graduating Not currently enrolled in school Homeless or has run away Has limited English proficiency

*Please note, this information is kept confidential and will not affect the youth’s ability to participate in programming. It is collected for anonymous grant reporting and program improvement purposes only.*

**YOUTH INFORMATION: PLEASE PRINT CLEARLY**

Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_

CYC program(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student ID Number ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_\_\_\_\_

**PARENTAL/GUARDIAN AGREEMENT**

***\*Please initial each item to indicate agreement to comply.***

*I authorize Community Youth Concepts (CYC) to act on my behalf in case my youth is victim of a major accident, injury, or illness when immediate medical or surgical care is needed; provided a member of CYC staff has made effort to first notify me of the situation and determine what my preferences are. If efforts to reach me are unsuccessful, I authorize duly licensed medical professionals to take such actions as their judgment dictates. I further agree that neither CYC, nor any person associated with CYC, has any responsibility of any kind to me or my youth from any claims arising from any accident, injury, or illness, which my youth may suffer as a result of any such health care of medical treatment. \_\_\_\_\_\_\_\**

*I authorize CYC to transport my youth to any field trips within the regularly scheduled program hours. I understand that only field trips or activities that function outside of regular scheduled hours will require my permission. \_\_\_\_\_\**

*When in the course of regular programming, I authorize CYC to photograph and capture video of my youth for publications and/or media presentations. If applicable, I authorize members of the media to photograph and capture video or my youth engaging in CYC activities or special events. I also authorize my youth to use CYC’s network and internet services. \_\_\_\_\_\**

*Additionally, I authorize CYC and/or contracted researchers of CYC to involve my youth in outcome measurement and evaluation of programs, and I give my permission for my youth’s school to release information to CYC regarding my youth’s grades, attendance, and disciplinary referrals. I understand that any data or information obtained from these activities will be treated with utmost confidentiality and my youth will not be individually identified as a participant. \_\_\_\_\_\**

*I understand that CYC expects youth to respect program participants and leaders, and any behavior that jeopardizes the safety of others may be considered grounds for removal from the program. \_\_\_\_\**

*I understand that basic information about my child will be anonymously shared with prospective mentors/advisors to aid in determining a suitable mach. Once a mentor/student match is determined, my and my child’s identity and other relevant information will be shared with the mentor to the extent it aids in facilitating a successful match.\_\_\_\_\_\_\**

*I understand that match meetings should take place at public locations; meetings at your home or the mentor’s home, or locations outside of the Des Moines Metro must first be cleared with CYC staff and parents/guardians. Overnight visits between you and your mentor are not allowed. \_\_\_\_\**

*Please list the name and phone number of a teacher or school staff that you have a good relationship with that we may contact regarding your participation in the program:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Youth Signature of Parent/Guardian Date

|  |
| --- |
| **Short Answers**  ***Please answer the following questions.*** |

1. In your opinion, what is the most significant issue facing Des Moines area youth? What type of project would you fund if you were given $2,000?
2. Describe some of your skills and interests by completing the following sentence. I am a person who…
3. Why do you want to be a part of uVoice: Youth Philanthropy Board?
4. Please list school, religious, social, athletic, or other activities or organizations in which you have participated during the last year.
5. Do you currently have a part-time job or regular volunteer position? If so, where and how many hours per week do you work?

**You can email applications to alicia@cyconcepts.org or send them to or drop them off at the CYC office at 1446 Martin Luther King Jr. Parkway, Des Moines, IA 50314.**