Parent/Guardian Informed Consent:

I give permission for my teen to participate in the Flourish/UNIFY adolescent sexual health programs that will be facilitated by a Public Health Educator from the Forsyth County Department of Public Health. I also release Forsyth County Department of Public Health, its staff, volunteers, and partners from any liabilities which may occur during any adolescent health sessions.

I understand that my teen has been invited to attend bi-weekly Flourish/UNIFY activities and sessions that will take place at Forsyth County Department of Public Health under the direct supervision of Forsyth County Department of Public Health program staff. Topics may include peer pressure, bullying, healthy relationships, abstinence, sex and its risks and effects, birth control options, and HIV/STDs prevention. I understand that through educational activities, my teen will learn or enhance skills related to communication, problem-solving, goal setting, and related topics that will empower them to make healthy lifestyle choices. I further understand that my teen will practice leadership skills and participate as a member of the session in various games, polls, and other engaging activities.

<u>Flourish Topics & Activities Include:</u> Textbook examples of female anatomy, mental health & resources, peer pressure & scenarios, journaling, puberty & menstrual cycles, diversity/culture, bullying, etc.
<u>UNIFY Topics & Activities Include:</u> Textbook examples of female & male anatomy, examples of birth control options, sexuality & identity, picture examples of STD's/STI's, journaling, substance abuse, condom application demonstrations, mental health & resources, etc.

I hereby give my teen permission to participate in the Flourish/UNIFY adolescent sexual health sessions and release the Forsyth County Department of Public Health, the host/coordinator of the adolescent health site, staff, and volunteers from any liability as a result of participation in the Flourish/UNIFY adolescent sexual health sessions.

_____ Yes, my student has permission to participate.

_____ No, my student does <u>NOT</u> have permission to participate.

Parent/Guardian Signature: _____ Date:_____

Flourish

Forsyth County Department of Public Health
Promoting Health, Improving Lives

UNIFY

Youth Program Enrollment Form

Please check the program you are enrolling your child/teen in:

☐ **Flourish (Girls ages 9–13)** ☐ **Unify (Coed, ages 14–18)**

Youth Information

Youth's Full Name: _____

Preferred Name: _____

Date of Birth: _____ **Age:** _____ **School/Grade:** _____

Preferred Pronouns: ☐ **She/Her** ☐ **He/Him** ☐ **They/Them** ☐ **Other:** _____

Parent/Guardian Information

Legal Parent/Guardian Name: _____

Home Address: _____

City: _____ **State:** _____ **ZIP:** _____

Primary Phone: _____ **Alternate Phone:** _____

Email Address: _____

May we send you text messages and program alerts? ☐ **Yes** ☐ **No**

Preferred Method(s) of Contact: ☐ **Text** ☐ **Email** ☐ **Phone Call**

Emergency Contact (if parent/guardian cannot be reached)

Name: _____

Relationship to Youth: _____ **Phone:** _____

Transportation

Do you need transportation assistance? ☐ **Yes** ☐ **No**

If yes, assistance is needed: ☐ **To Sessions** ☐ **From Sessions** ☐ **Both**

Health & Support Information

Does your child/teen have any allergies, dietary restrictions, medications, or other health concerns we should know about?

_____

_____

Does your child/teen have any physical, emotional, behavioral, learning, or accessibility needs that would help us support them during programming?

_____

_____

Flourish

Forsyth County Department of Public Health
Promoting Health, Improving Lives

UNIFY

Additional Information

Is there anything else you would like program staff to know about your child/teen?

_____

_____

Parent/Guardian Permission

I confirm that the information provided above is accurate to the best of my knowledge. I give permission for my child/teen to participate in the selected Flourish or Unify program. I understand that program staff may contact me regarding scheduling, transportation, program updates, and emergencies.

Parent/Guardian Signature: _____ Date: _____

For program use only

Date Received: _____

Staff Initials: _____

Transportation Follow-Up Needed:

☐ **Yes**

☐ **No**

Complete and Return to
Adolescent Health Coordinator
Tenesha M. McDuffie, MPH, CHES
mcdufftm@forsyth.cc
Phone: 336-703-3180
799 N. Highland Ave Winston-Salem, NC 27101