



Atrium Health

Gen Z COVID-19 Vaccine Ambassadors Program

PARENT/GUARDIAN CONSENT FOR MINORS TO VOLUNTEER

The Youth COVID-19 Ambassador Program (“the Program”) is an educational program where Atrium Health clinicians train youth to be a resource for friends, family and coworkers to educate on the COVID-19.

All participants under the age of 18 must submit this form signed by the parent(s) or legal guardian(s) before volunteering for the program.

MINOR'S NAME:

PARENT/GUARDIAN NAME:

RELATIONSHIP TO MINOR PARTICIPANT:

ADDRESS:

PHONE:

EMAIL:

You acknowledge the following Program responsibilities:

- Attend scheduled educational sessions
- Use technology responsibly for purposes of the Program (appropriate language in all email and virtual communications)
- Receive weekly e-mails containing information to be shared with family and friends
- Be an ambassador for COVID-19 vaccination when engaging with your community in person and through social media platforms
- Access an online library of resources to assist in education and communications
- Communicate to staff if you have ideas, questions or concerns regarding training

CONSENT TO RECORDING

I hereby authorize Atrium Health to photograph and video/audio record (“Record”) my child during the Program, and use or distribute any photograph, audio or video recording (“Materials”) related to Program activities that my child is depicted in. I also authorize use of these Materials for publication in a brochure or other Atrium Health published material. Materials may also be distributed to other Program participants, or the public for educational purposes.

RELEASE AND WAIVER OF LIABILITY

I HEREBY EXPRESSLY RECOGNIZE AND ASSUME ALL RISKS ASSOCIATED WITH MY CHILD'S PARTICIPATION IN THE PROGRAM AND RELEASE AND DISCHARGE THE ATRIUM HEALTH FROM ANY AND ALL CLAIMS, DAMAGES, LOSSES OR EXPENSES OF WHATEVER KIND OR NATURE WHICH SAID MINOR MAY HAVE OR ACQUIRE ARISING OUT OF OR RESULTING FROM DIRECTLY OR INDIRECTLY, HIS/HER PARTICIPATION IN THE YOUTH COVID-19 AMBASSADORS PROGRAM.

Please sign below to acknowledge that your child has your permission to become involved with the Atrium Health Youth COVID-19 Ambassadors Program.

I have read and fully understand the Youth COVID-19 Ambassadors Program terms and Program responsibilities and I consent to participation.

STUDENT SIGNATURE: _____

DATE: _____

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____



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