UCDAVIS
SCHOOL OF MEDICINE
Office of Student and Resident Diversity

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

Health Career **EXPOSURE** - Academic **ENRICHMENT** - Youth **EMPOWERMENT**

HEALTH *(formally Saturday Academy)* introduces high school students to various health professions, medical technology, and human systems. In conjunction with strength-based leadership training, the program's emphasis is on community leadership, health disparities, and future opportunities in health care.

Program Highlights

- Meet with health professionals and students
- Different pathways to a career in health care
- Leadership development
- Focus on an issue in your community
- FREE

Who is eligible?

Teams of 4-6 students from high schools in Yolo, Solano, or Sacramento Counties who are interested in health careers and committed to attending all sessions.

Orientation February 11, 2019

Session dates:

February 23

March 2, 9, 23 April 6 & 13

Health Equity Academy Goal

To spark students' interest in improving community health for Californians.

Team members are not required to be from the same high school; each applicant is required to complete and submit an application.

Additional questions? Just call or email cmtorres@ucdavis.edu

Program Contact **Spring Applications Due Feb. 1** Interview may be required

Charrise Torres, Education Pipeline Coordinator
Office of Student and Resident Diversity, UC Davis School of Medicine
cmtorres@ucdavis.edu / (916) 734-8024 https://health.ucdavis.edu/diversity/k12_outreach.html

UCDAVIS HEALTH | SCHOOL OF MEDICINE

UCDAVIS SCHOOL OF MEDICINE
Office of Student and Resident Diversity

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

Program Application

Family Orientation Monday, February 11th 6:00-7:00pm
February 23, 2019 – April 13, 2019 9:00 am to 3:00 pm
ATTENDANCE IS REQUIRED FOR ALL SESSIONS

Directions: *Please complete the application in its entirety using a black or blue pen. Please ensure that your writing is legible, especially your email and phone number. Incomplete or late applications* ***will not*** *be considered. Application deadline is 5:00pm on Friday, February 1, 2019.*

APPLICANT INFORMATION					
Last Name		First		M.I.	
Street Address				Apartment/Unit #	
City		State		ZIP	
Phone		E-mail Address			
Parent/Guardian Name		Emergency Contact Name			
Parent/Guardian Phone		Emergency Contact Phone			
Parent/Guardian Email		Emergency Contact Relationship to Applicant			
Applicant Date of Birth		If applicable: Previously completed program: (Saturday Academy, Medical Explorers, Summer Scrubs, etc.)			

DEMOGRAPHIC INFORMATION			
How do you identify in terms of race and ethnicity? Please select all that apply:			
American Indian or Alaska Native	☐	Mexican or Mexican American	☐
Chinese or Chinese American	☐	Latino/Hispanic	☐
Black or African American	☐	Ukrainian	☐
Native Hawaiian or Other Pacific Islander	☐	Hmong	☐
Middle Eastern	☐	White/Caucasian	☐
East Indian/Pakistani	☐	Prefer not to say	☐
Vietnamese/Vietnamese American	☐	Other (list your choice to the right)….	☐

GENDER INFORMATION

How do you identify? Please select all that apply:

Female	☐	Transgender	☐
Male	☐	Prefer to self-describe:	☐
Non-binary/ third gender	☐	Prefer not to say	☐

ADA ACCOMMODATIONS

Please describe any ADA accommodations you will need to participate in this program.

MEDICAL INFORMTAION

Please describe any ADA Allergies or Health Conditions we need to be aware of.

FOOD PREFERENCE

Do you have any special dietary restrictions (i.e. vegetarian, gluten or nut allergy, etc.)?

INTEREST AND QUESTIONAIRE

In three or more sentences please answer the following three questions. (You may attach a separate sheet of paper.)
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 the HEALTH Equity Academy - Leading Tomorrow’s Health and what do you hope to gain?

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

- ☐ DDS or DDM Doctor of Dental Surgery or Doctor of Dental Medicine
- ☐ Dental Assistant
- ☐ 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 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.		

DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge.

Student Signature:	Date
Parent/Guardian Signature:	Date
Parent/Guardian Signature:	Date
Parent/Guardian Signature:	Date

DOCUMENT CHECKLIST

- ☐ 2019 HEALTH Academy Application
- ☐ Risk and Liability Waiver
- ☐ Media Waiver

Submit completed application with documents

- Scan and email to cmtorres@ucdavis.edu
- Fax to 916-703-5568
- or mail hard copy to:
  Attn: Charrise Torres
  UC Davis School of Medicine
  Education Building Suite 4101
  4610 X Street, Sacramento CA 95817

Application deadline:
5:00 PM on Friday, February 1, 2019
Late applications will not be considered.

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 2019 HEALTH Equity Academy

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) _____

Rev: 2.19.15

UC DAVIS SCHOOL OF MEDCINE

2019 HEALTH Equity Academy

Medical Information & Authorization Form

PROGRAM DATES: Saturday Feb. 23, 2019 – April 13, 2019

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 (circle those that apply):

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

EMERGENCY CONTACT INFORMATION

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

CELL PHON #: _____ **ALTERNATE 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.

_____ _____ _____

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

School of Medicine
University of California, Davis

Media Reproduction Waiver

*This waiver allows the **UCD 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