



Teen Wellness Team Parent/Guardian Permission Form

Name of Teen: _____

Emergency Contact Details:

Name: _____

Relationship: _____

Phone: _____

I give permission for the Teen Wellness Team member named above to attend and participate in learning sessions at least once a month on the third Wednesday of each month. All meetings will take place exclusively on Zoom from 6 - 8 p.m. on the following dates:

- Oct. 30, 2024.
- Nov. 20, 2024.
- Dec. 18, 2024.
- Jan. 15, 2025.
- Feb. 19, 2025.
- March 19, 2025.
- April 16, 2025. (In-person optional.)
- May 21, 2025.

Additional meeting sessions may be scheduled if necessary. The dates and times of these sessions will be announced and communicated to Teen Wellness Team members.

Teens will receive a stipend of \$14 per hour for attending monthly learning sessions via Zoom. Teens are expected to:

- Attend virtual meetings. The teen must be present for at least 80% of the meeting to receive the stipend. The [Ohio Adolescent Health Partnership](#) (OAHP) coordinator manages the stipend payment. OAHP is a diverse group of agencies, organizations and individuals with expertise in adolescent health and wellness, with the common goal of supporting optimal health and development for all adolescents.
- Actively participate and provide feedback on programs.
- Maintain regular communication with Teen Wellness Team Coordinator.

I hereby release, discharge, indemnify and hold harmless the Ohio Department of Health and its officers, agents, employees, staff and volunteers, and any other persons or entities acting on its behalf and their successors or assigns, against all claims, demands and causes of action whatsoever either in law or in equity, related to injury, disability, death or other harm, to person or property or both, arising from Teen Wellness Team member's participation in any and all, Teen Wellness Team events throughout 2023-24. I permit images, video or audio recordings of my child taken during events to be used in publicity materials of the Ohio Department of Health.

I understand that my teen will be discussing health topics and will be asked to give feedback on programs.

Parent/Guardian Signature _____ Date: _____

Relationship _____

Full Name _____

If you have any questions, please contact Jen Casertano Jennifer.casertano@odh.ohio.gov.