

**Massachusetts Tobacco Cessation and Prevention Program
Youth Tobacco Compliance Application**

All information will be kept confidential!

The following information is needed so that youth can be contacted about the training, conducting checks, and be paid. An FDA Compliance Officer or someone from the local youth tobacco program will be contacting youth to set up the online training.

Youth Name: _____ **Date of Birth:** _____

Home Address: _____

City/Town: _____ **Zip Code:** _____

Youth Cell Phone Number: _____ **Youth Home Phone Number:** _____

Youth Email: _____

School Attending: _____ **City/Town of School:** _____

Social Security Number: _____

Parent/Guardian Name: _____

Parent/Guardian Phone Number: _____

Parent/Guardian Email: _____

Please tell us anything about your availability (Ex. Not available in fall because of sports)

How did you hear about this position? (please be specific)

Preferred Method of Communication: (Please circle) Text Home Phone Cell Phone Email

Please mail or scan and email the following items to Jenna Carter:

- ___ **Youth Tobacco Compliance Application**
- ___ **Parent Consent and Release form**
- ___ **Youth Agreement**
- ___ **Medical Treatment Authorization form**
- ___ **Birth Certificate** (a copy)
- ___ **Social Security Card** (a copy)
- ___ **A clear portrait photograph**

Jenna Carter, Health Resources in Action
95 Berkeley Street, Suite 208
Boston, MA 02116
tobaccoundercover@hria.org

**Health Resources in Action, The 84 Movement
Parent/Guardian Consent and Release Form**

Dear Parent/Guardian:

Your son or daughter has expressed an interest in assisting Health Resources in Action (HRiA) and/or the local tobacco coalition, and the Massachusetts Tobacco Cessation and Prevention (MTCP) Program in preventing the illegal sale of tobacco products to underage youth. With your permission, your child will help us to conduct compliance checks by visiting local tobacco retailers and attempting to purchase tobacco products. Your child's activities will be under the direct supervision of a Food and Drug Administration (FDA) Tobacco Inspector or a representative from a local Board of Health.

Each potential undercover buyer will be trained with respect to standard compliance check procedure. Money to purchase tobacco products will be provided. Any tobacco products purchased by the youth involved in this project will be retained by the staff person and labeled as evidence. Massachusetts law does not prohibit children from buying tobacco, so your child will not be violating any law by participating in compliance checks. While your son/daughter will spend the majority of their time conducting checks, they may also need to be called as a witness to testify regarding the compliance check in which they participated. Stipends will vary based on the program the youth is conducting checks. If you have any questions about what the project will entail, please feel free to call the local Board of Health program where you obtained this application or Jenna Carter, HRiA Administrative Coordinator at (617) 279-2240, x373.

PARENT OR GUARDIAN CONSENT AND RELEASE FORM

- I give my consent for my son/daughter's participation in the tobacco compliance check project described above, including the orientation and training.
- I give consent for my son/daughter to ride in a vehicle with an adult working on the compliance check.
- I give consent for my son/daughter's photograph to be taken during a training session or while conducting checks to be used for the project. I understand that these photos will not be publically published and that I will not be paid for use of these photos. I do not hold The 84 Movement, Health Resources in Action or the programs associated with the Massachusetts Department of Public Health responsible for any damages raised out of use of the photos.
- Identities of Minors are to remain as confidential as possible. However, in the event of possible enforcement or judicial action, the Minor's identity may be revealed and the Minor may need to provide a declaration and/or give testimony in a hearing. Minors must be available to testify as witnesses in administrative hearings for a minimum of 5 years after each inspection. Minors will be contacted bi-annually to confirm that their contact information is up to date for 5 years after the last date of inspection.
- I give consent for my son/daughter's contact information to be shared with representatives from Boards of Health in order to contact my son/daughter to conduct compliance checks.

As parent and/or legal guardian, I agree on behalf of myself, my child, or our heirs, successors and assigns, to hold harmless and defend Health Resources in Action, the local Board of Health program, and its agents, employees, officers and directors, as well as the sponsors of the activity and their agents, employees, officers and directors from any and all actions, claims, demands, damages, costs, expenses and all consequential damage arising from or in connection with my child attending the activity or in connection with any illness or injury or cost of medical treatment in connection therewith; provided, however, that this indemnity will not apply with respect to any claims for injury to the extent of any available and applicable motor vehicle insurance or other liability insurance.

If I have any questions about this program, I understand that I can contact the local tobacco program or Jenna Carter, Administrative Coordinator of Health Resources in Action at 617-279-2240 x373 or tobaccoundercover@hria.org

Youth's Name (please print): _____ Date of Birth: _____

Parent/Guardian's Name (please print): _____

Parent/Guardian's Signature: _____ Date: _____

Massachusetts Tobacco Cessation and Prevention Program

Medical Treatment Authorization

*This form is to be filled out by the parent/guardian of the youth inspector and will be kept on file in the case of an emergency during work hours. **PLEASE NOTE: Save the original, signed copy to give to the Compliance Officer upon working your first inspection. Send a signed copy in with the rest of the application.***

Minor's Name: _____

Home Address: _____

Date of Birth: _____

Gender: _____

Medical Information:

Primary Care Physician's Name: _____

Phone #: (____) _____

Medical Insurance Provider: _____ Policy #: _____

Allergies to Medications: _____

Medical Conditions for which the minor is receiving treatment:

Prescription Drugs the minor is taking:

Other pertinent medical information:

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S) As custodian of the aforementioned minor, I grant my authorization and consent for a designated adult to administer general first aid treatment for minor injuries or illnesses. If the injury or illness is severe, I authorize him or her to seek professional emergency personnel to attend, transport, and treat the minor and to issue consent for any medical care deemed advisable by a licensed medical professional or institution. I authorize the designated adult to exercise best judgment upon the advice of medical or emergency personnel.

Effective Date: _____

_____. Signed this ___ day of

_____, 20__ .

Parent / Guardian Signature:

Printed Name: _____

**Massachusetts Tobacco Cessation and Prevention Program
Youth Agreement**

Name (please print): _____

INSTRUCTIONS: Please read each item below. Your signature signifies your agreement to the following:

1. I understand that the purpose of the Tobacco Compliance Check project is to encourage the increased enforcement of laws that ban the sale of tobacco to underage youth.
2. I agree that I will meet with Tobacco Compliance Officers at the location and time specified for each compliance check.
3. I understand that specific information about the compliance checks I will conduct are confidential, and that I will not discuss such details such as store names and locations unless directed to do so by Tobacco Compliance Officers.
4. I understand that Massachusetts law does not ban underage youth from attempting to purchase tobacco; therefore, I will not be violating any laws while participating in this activity.
5. I agree not to pursue or participate in any attempt to purchase tobacco products except when I am supervised by Tobacco Compliance Officers.
6. I agree to give any tobacco products, change or unused money that is not my own to the Tobacco Compliance Officers.
7. I am aware that I may need to complete and sign narrative reports and/or may be called as a witness to testify regarding the compliance check in which I participated.
8. I agree to follow the procedures explained to me during the Tobacco Compliance Check training session while conducting tobacco compliance checks.
9. I understand that I must be available to testify as a witness in administrative hearings for a minimum of 5 years after each inspection. I understand that if I move, change email addresses, phone numbers, etc, that I must contact HRiA or the local tobacco program to keep my contact information current. I am responsible for doing this for 5 years after the date that I stop doing inspections. HRiA will contact me twice a year as well to make sure that my contact information is up to date.

_____ Date: _____
Youth Signature

-----Office Only-----

Minor ID: _____ DOB: _____