

# Youth Medical Explorers (YME) Application



## Contact Information

Name:			
Street Address:			
City/ St/ Zip Code:			
Cell Phone:		Text?	YES <input type="checkbox"/> NO <input type="checkbox"/>
E-Mail:			
High School :		Grade:	
Parent/Guardian Name(s):		T Shirt (unisex) Size:	
Parent/Guardian Email:		Parent/Guardian/ Emergency Contact Phone:	

## Please explain your career goals and the areas of interest within health care. What do you hope to gain from participating?

## YME & HOSA

Sanford YME is a HOSA Chapter (Future Health Professionals). YME students will be automatically members of the Sanford HOSA chapter unless the high school is a designated chapter.	My High School is a HOSA chapter: YES <input type="checkbox"/> NO <input type="checkbox"/>
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Consent of Audiovisual Recording Photos	
I am hereby informed that there may be audiovisual recording and photography throughout the YME program. I consent to audio and visual recording or photography at any or all times while at Sanford facilities. I understand that these images containing my image may be used as part of the educational mission of YME.	YES <input type="checkbox"/> NO <input type="checkbox"/>
Program Preference	
The school year program will be held from 6:30pm to 8:00pm one or two evenings a month during the school year from September – April.	<b>School year</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
Summer program consists of 3 consecutive days from 1:00pm to 3:00pm. Attendance each day is essential.	<b>Summer</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
Contract	
<b>Your commitment to the program upon acceptance is necessary. One un-excused absence or 3 excused absences will be allowed for the school year program. Attendance during the 3-day summer program is mandatory. I commit to the program's attendance policy.</b>	YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>I acknowledge that Sanford Health is providing me with access to individuals and facilities where individually identifiable health information is protected by state and federal laws and regulations and the policies and practices of Sanford Health.</b>	YES <input type="checkbox"/> NO <input type="checkbox"/>  <b>X</b> _____ Student's Signature
<b>As parent/guardian of this applicant, I support his/her participation in and commitment to the Sanford Youth Medical Explorers experience.</b>	YES <input type="checkbox"/> NO <input type="checkbox"/>  <b>X</b> _____ Parent/Guardian's Signature

**Send completed application to:**

**Scan & Fax:** 605-312-9837

**Email:** [kelley.yseth@sanfordhealth.org](mailto:kelley.yseth@sanfordhealth.org)

**Mail:** Sanford Health

Attn: Attention: Kelley Yseth / LEAD

2200 E Benson Rd, Route #5203

Sioux Falls, SD 57104