MUSC CHILDREN'S HEALTH
YOUTH ADVISORY COUNCIL
APPLICATION

☐ I am interested in becoming a member of the MUSC Children's Health Youth Advisory Council!

☐ I have been a patient or sibling of a patient at MUSC Children's Hospital.

☐ I am between 13 and 18 years of age.

☐ I understand that I will be attending Youth Council meetings at MUSC and possibly other events, sponsored by the Children's Hospital, as a Youth Representative.

☐ I understand I will be asked to share my opinions, ideas and comments about the hospital, healthcare and I am comfortable speaking in a group setting.

☐ I have spoken with my parents or guardians. They support my desire to join the Youth Council and will provide transportation to meetings.

Date:_____

Name:_____

Age: _____**Birthday**_____

Cell Phone_____ **Other phone**_____

E-mail_____

Address_____

_____

T-shirt size:_____

I prefer to be contacted by ☐ **phone** ☐ **text** ☐ **e-mail**

School and grade:_____

Interests and hobbies: _____

_____

_____

Parent or guardian name:_____

Phone number (cell) _____

Email_____

Parent or guardian name: _____

Phone number (cell)_____

Email_____

A little about my diagnosis and medical story:

_____

_____

_____

_____

_____

Clinics, units, procedure areas (Operating Room, cath lab, x-ray, MRI, etc…) where I have received care:

_____

_____

_____

My MUSC Children's Hospital physician(s):

_____

_____

Why I want to be a part of the MUSC Children's Health Youth Advisory Council:

_____

_____

_____

_____

_____

Ideas or suggestions I would like to discuss at YAC:

_____

_____

_____

_____

Please mail or e-mail this application to:

Betsy McMillan, Child Life Department
165 Ashley Avenue MSC 355
MUSC Children's Health
Charleston, SC 29425
mcmillbm@musc.edu
843-792-7064 (work)

Please attach a recommendation to application from an adult (other than your parent or guardian)