

Youth Advisory Council

Application form



Yes! I'm interested in becoming an active member of the Youth Advisory Council at Children's.

- I have talked to my parents or guardians. I am able to attend meetings one Saturday morning per month.
- I am willing to share my thoughts and ideas about the hospital with other group members.
- I am between 8 and 18 years of age.
- I have asked another adult for a recommendation.

About me

Name _____

Address _____

City	State	Zip
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Phone number _____

Birth date _____

Your signature _____

Why I want to be part of the council:

Here's how I've had contact with Children's:

My parents' or guardians' approval

Parent/Guardian's name _____

Signature _____

An adult's recommendation

Please ask an adult, other than your parent or guardian, to fill out this portion of the application.

Adult's name _____

Signature _____

Phone number _____

I recommend _____ for the Youth Advisory Council because

Return this application

Complete this application and mail it to:
Children's Hospitals and Clinics of Minnesota
ATTN: Child Life, Mail Stop 32-2710
2525 Chicago Avenue South
Minneapolis, MN 55404

You can also e-mail information to sheila.palm@childrensmn.org.