Camp Med Summer Program at Northern Regional Hospital

June 23-27, 2025
9:00 am—4:00 pm

What is Camp Med?

Camp Med is a program that is designed to identify, recruit, educate, and prepare high school students for careers in health professions.

Applicant Requirements:

- Current 9th-12th grade students (for the 2024-2025 school year) who have an interest in health careers
- Must have a minimum 2.5 GPA
- Must complete a letter of interest outlining your career goals and why you want to participate in Camp Med
- Complete application process

Camp Med Objectives:

- Expose students to healthcare careers
- Understand healthcare challenges of our time
- Engage students with healthcare career related activities
- Reflect on local healthcare strengths, weaknesses, opportunities and challenges

Camp Activities:

- Presentations
- Tours
- Interactive, hands-on stations
- Animal dissection
- Hands-on labs
- CPR certification
- Community service project

Application Deadline: March 28, 2025

Applications can be requested at your school or by contacting:

Tina Beasley
336-783-8196
tbeasley@wearenorthern.org

Dan Combs
336-783-8199
dcombs@wearenorthern.org

Camp Med is made possible through funding by Northwest Area Health Education Center (AHEC), a program of Wake Forest School of Medicine and part of the NC AHEC System.

HIGH SCHOOL STUDENTS:

YOU'RE INVITED TO PARTICIPATE IN CAMP MED 2025 SUMMER PROGRAM

Camp Med 2025 Summer Program is a great way to expose student to the world of possibilities in health careers. Now more than ever the need for talented healthcare work force is a necessity. Students will be exposed to the stimulating world of working in healthcare and reflect on social determinants of health.

Registration is FREE and the program is available as either:

1. **IN PERSON Camp Med -** (Current 9th-12th Graders for the 2024-25 School Year): Northwest AHEC works with coordinators through local school systems. Camps will be county based and potentially held in the following counites - Alexander, Alleghany, Ashe, Avery, Burke, Caldwell, Catawba, Davidson, Davie, Forsyth, Iredell, Rowan, Stokes, Surry, Watauga, Wilkes and Yadkin.
2. **VIRTUAL Camp Med -** (Current 8th-12th Graders for the 2024-25 School Year): To receive a Virtual Camp Med completer certificate, students are required to complete all the module activities. The Camp Med virtual experience on health career exploration is composed of 5 modules designed for you to complete on your own time. Virtual Camp Med will begin on June 1, 2025 and end on July 31, 2025.

Students will experience 20+ hours of designed programming and have a fun and rewarding time while acquiring knowledge and skills that will help them to make informed decisions on their future careers in healthcare.

Camp Med Objectives

- Expose students to healthcare careers
- Understand current healthcare challenges
- Engage students with healthcare career-related activities
- Examine local healthcare opportunities

The program is FREE. Visit www.nwahec.org/campmed for more information!

Northwest Area Health Education Center is program of Wake Forest University School of Medicine and part of the North Carolina AHEC program that provides and supports educational activities needed to create a healthy North Carolina.

Melanee W. Mills
Health Careers and Workforce Diversity Coordinator
336.713.7714 \ mgmills@wakehealth.edu

Wake Forest University School of Medicine

NORTHWEST AHEC
PART OF NC AHEC

Camp Med 2025 Application

(PRINT CLEALY OR TYPE)

Student Name: First MI Last

Permanent Mailing Address City State Zip Code

(_____)_____ (___)_____

Home Phone # **Cell Phone #** **Email**

____/____/_____

Birthdate (mm/dd/yyyy)

Gender: ☐ Male ☐ Female ☐ Decline to Answer

Lab Coat Size (Adult sizes):
☐ Small ☐ Med ☐ Large ☐ XL ☐ 2X ☐ 3X

T-shirt Size:
☐ Small ☐ Med ☐ Large ☐ XL ☐ 2X ☐ 3X

DEMOGRAPHIC DATA:

Ethnicity:

___ Hispanic/Latino ___ Non-Hispanic/Latino

Race:

___ American Indian or Alaskan Native
___ Asian
___ Hispanic or Latino
___ Native Hawaiian or other Pacific Islander
___ Black or African American
___ White or Caucasian
___ More than one race

For Camp Med data collection regarding health professions shortage purposes only. This information is a requirement of the US Department of Health and Human Services. It will not be criteria for selection into the program.

SCHOOL VERIFICATION: (2024 - 2025 School Year)

Current Grade Level: _____

Name of School Presently Attending: _____

School Address: _____

School Phone #: (_____) _____

The above student applicant has had no significant disciplinary or attendance problems and has a minimum of a 2.5 GPA. I recommend for participation in Camp Med.

Principal's / Counselor's Signature _____ **Date** _____

Wake Forest School of Medicine is committed to abide by all local, state and national laws, and to administer all educational and employment activities without discrimination because of race, color, religion, national origin, age, marital status, physical handicap, or sex (except where sex is a bona fide occupational qualification or statutory requirement).

PARENT/GUARDIAN INFORMATION:

Primary Contact Name: First _____ **MI** _____ **Last** _____

Relationship to Student: _____

Mailing Address: _____ **City** _____ **State** _____ **Zip Code** _____

Home Phone #: (_____) _____ **Cell #: (_____)** _____ **Work #: (_____)** _____

STUDENT and PARENT/GUARDIAN COMMITMENT: We understand that students apply to attend Camp Med as an optional school activity. We understand that with acceptance, satisfactory behavior, conduct, academic progress, and regular attendance is mandatory for continued participation in Camp Med. With that acceptance also comes the responsibility to maintain a mature, professional appearance. Due to contact with health care facilities and personnel, a higher standard of appearance is expected. We agree to abide by all school policies including the Camp Med policies.

Student's Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

IMPORTANT: Completed Application with Letter of Interest must be returned to Camp Med Coordinator no later than **March 28, 2025**

Direct your questions to:

Tina Beasley, Camp Coordinator
tbeasley@wearenorthern.org
336-783-8196

or

Dan Combs, Camp Coordinator
dcombs@wearenorthern.org
336-783-8199

Return required documents to:

Northern Regional Hospital
Attn: Tina Beasley
P.O. Box 1101
Mount Airy, NC 27030

Camp MED 2025

Wake Forest School of Medicine
Northwest Area Health Education Center

ASSUMPTION OF RISK AND RELEASE FORM

THIS IS A LEGAL DOCUMENT – READ CAREFULLY BEFORE SIGNING

I, the undersigned, hereby certify that I am the parent or legal guardian of _____ who will be participating in **Camp MED** sponsored by the Northwest Area Health Education Center (NW AHEC) of Wake Forest School of Medicine.

Permission and Voluntary Participation. I hereby give my permission for _____ to participate in the various activities with **Camp MED** including, but not limited to, participation in health career presentations, tours of departments and laboratories, observing medical and research professionals at work, field trips, hands on educational and various recreational activities. I further acknowledge that my child voluntarily chooses to participate in **Camp MED** (including all activities) and my child and I voluntarily assume all risks associated to include COVID-19 risk therewith. I further agree to assume any and all risks involved in the transportation of and participation by my child in **Camp MED**.

Risks of Program. I understand that this program involves activities and various recreational activities, and exposes my child to certain risks and dangers. Some of the risks associated with **Camp MED** include, but are not limited to, the following:

- The hazards of travel by car, van, bus, or other forms of transportation
- Exposure to risks normally found in public places and medical facilities, including exposure to infectious, communicable and other diseases and viruses
- The potential of injury as a result of the criminal, negligent, or injurious acts of others
- Physical exertion or emotional distress associated with activities undertaken
- Loss of valuable personal property
- Injury resulting in serious, permanent physical injury, or even death, resulting from accident, natural disasters or acts of God; from strikes, protest, riot, etc., or from medical care or treatment received incident to such injury

Fitness to Participate. Understanding the above-mentioned risks, and understanding that participation in **Camp MED** may subject me to physical exertion, I hereby state that, unless I have informed Melanee Mills, **Camp MED** program coordinator, otherwise in writing, my child is physically fit to participate in **Camp MED**. I also acknowledge that my child is up-to-date on all of his/her immunizations.

Release of Claims. Knowing the risks described above, I release Wake Forest School of Medicine and Wake Forest Health Sciences, its officers, directors, employees, and agents; Wake Forest University, its trustees, officers, employees, and agents; and Wake Forest Baptist Medical Center, its officers and agents, from any and all liabilities, claims, or demands for damages for personal injury, disability, property damage or other loss of any kind that my child may sustain as a result of his or her participation in **Camp MED**, whether such loss results from the negligence of such released parties or otherwise (except for claims or liability arising directly from the gross negligence of such parties). I further agree to indemnify and hold harmless Wake Forest Health Sciences, its officers, directors, employees, and agents, from any and all loss, liability, damage or costs that it or they may incur as a result of my child's participation in **Camp MED** or arising from any of my acts or omissions or from the acts or omissions of my child.

My child and I agree to comply with all the rules, regulations and policies of Wake Forest Health Sciences and Wake Forest University, including those applicable generally and those pertaining specifically to **Camp MED**. I acknowledge that the program coordinator or other authorized officials may from time to time establish rules and policies for the program which may be announced orally or in writing. I understand that each site or location at which my child may participate in connection with **Camp MED** has its own rules, policies, and standards of acceptable conduct, including but not limited to those related to dress, safety and behavior. My child and I recognize that behavior which violates these rules, policies or standards could harm the University's relations with these programs, as well as my child's own health

and safety. My child and I will become informed of and abide by all such rules, policies, and standards for each service in which my child will be involved during my participation in **Camp MED**.

Medical Treatment Authorization. Camp MED, Northwest Area Health Education Center (AHEC) and Wake Forest Health Sciences, including its employees, officers, and agents, and Wake Forest University, its employees, officers, and agents, are authorized (but are not obligated) to take any actions (including notification of parents or guardian) it considers to be warranted under the circumstances regarding my child's health and safety. I agree to pay all expenses related thereto and hereby release **Camp MED, Northwest AHEC** and Wake Forest Health Sciences, including its officers, directors, employees, and agents, and Wake Forest University, its officers, trustees, employees, and agents, from any liability for any such actions or for payment for such authorized treatment.

My child is presently covered by standard health insurance providing for medical treatment, and such insurance will be fully effective during the entire period of my child's participation in **Camp MED**. My child's health insurance information is as follows:

Name of the insuring company: _____

Address: _____

Name of primary policy holder: _____

Group number of this policy: _____

Individual policy number: _____

List any physical condition, treatment, or medication that a health care professional should be aware of (i.e., food allergies, car sickness, asthma, etc.) while your child is attending **Camp MED**. All information and instructions must be in writing. Attach a separate sheet to this Assumption of Risk and Release if necessary:

Special Precautions: _____

Medications to be taken: _____

*Medications, along with written instructions, should be given directly to the counselors at registration.

Person to notify in case of emergency, illness or accident (if unable to notify parent or legal guardian stated below):

Name: _____

Address:_____

_____

Telephone: (home)_____ (work) _____ (cell) _____

I am the parent or legal guardian of the above participant and have read and understand the foregoing assumption of risk and release form. I am and will be legally responsible for the obligations and acts of the participant as described in this assumption of risk and release form and agree, for myself and for the participant, to be bound by its terms.

Signature of parent/guardian: _____

Printed name of parent/guardian: _____

Parent address:_____

_____

Parent Email _____

Telephone number where you can be reached: (home) _____ (work) _____(cell)_____

Date:_____

Student Name:_____ DOB:_____

Grade:_____ High School:_____ Male: ___ Female: ___Ethnicity:_____ County:_____

Student Cell: _____ Student Email: _____

WAKE FOREST BAPTIST HEALTH
NON-EMPLOYEE
CONFIDENTIALITY AGREEMENT

Wake Forest University Health Sciences and North Carolina Baptist Hospital, along with their subsidiaries (collectively, "the Medical Center") have, and will develop further, confidential, proprietary information and trade secrets relating to their clinical, research and educational missions.

These trade secrets and confidential and proprietary information include but are not limited to, information concerning patients, research studies and subjects, animal care and use, faculty, staff, and students, planning, financial and donor information, prices, pricing methods, costs, procedures or processes for the Medical Center's business, fixtures, research and development methods, projects, data, goals or activities, business strategies, research techniques, the identities or addresses of the Medical Center's employees or their functions, confidential reports prepared for the Medical Center by business consultants, or any other information concerning the Medical Center or its business that is not readily and easily available to the public or to those in the Medical Center's business (any and all of which shall be referred to in this Agreement as "Information"). In the course of my relationship with the Medical Center, I may have access to such Information, and I understand and acknowledge the importance of protecting the confidentiality of such Information.

In consideration of my continued relationship, by signing this Agreement, I understand and agree to the following:

1. I may use Information disclosed to me solely in the course of my relationship with the Medical Center. I may not use Information for any other purpose.

2. During and after my relationship, I will hold all Information in the strictest confidence and will not disclose any Information or any portion of the Information to any other firm, entity, institution, or person, except that I may disclose the Information on a confidential basis to other employees and agents of the Medical Center on a "need to know" basis in the course of my relationship with the Medical Center. I understand and agree that my obligation to keep Information confidential forbids me to disclose Information even to family members or friends, and even when identifying details are not revealed.

3. I understand and agree that all property of and data and records with respect to the Medical Center and its affiliates coming into my possession or kept by me in connection with my relationship with the Medical Center, including without limitation, correspondence, management studies, research records, notebooks, blueprints, computer programs, software and documentation, bulletins, reports, patient lists, student and employment data, costs, purchasing and marketing information, are the exclusive property of the Medical Center. I agree to return to the Medical Center all such property and all copies of such data and records upon termination of my relationship or as otherwise directed by the Medical Center.

4. I understand that the Information is of a private, internal, or confidential nature and constitutes a valuable, special and unique asset of the Medical Center and its affiliates.

5. I understand a material breach of this Agreement will cause irreparable damage to the Medical Center and its affiliates, and that such damage will be difficult to quantify and for which money damages alone will not be adequate. Accordingly, I agree that the Medical Center, in addition to any other legal rights or remedies available to the Medical Center on account of a breach or threatened breach of this Agreement, shall have the right to obtain an injunction against me

enjoining any such breach without the need for posting a bond, and I waive the defense in any equitable proceeding that there is an adequate remedy at law for such breach.

6. I will not access any Information or area of the Medical Center that I have not been authorized to access. I will not discuss Information in areas where others who do not have a need to know such Information may overhear the conversation (e.g. hallways, elevators, cafeterias, shuttle buses, public transportation, restaurants, and social events).

7. I will not access any Information for other persons or employees who do not have the right to access the Information themselves. I will not disclose my or any other Medical Center employee's computer password(s) to anyone, nor will I use another person's password(s) instead of my own for any reason unless authorized by my point of contact or unless required by the Medical Center's Information Systems Department for maintenance reasons. I will inform my point of contact immediately if I know or have reason to believe someone without proper authority knows or is using my password(s).

8. I will not:
   a. make any personal or unauthorized inquiries* into any Medical Center computer or system;
   b. make any personal or unauthorized transmissions* [i] of any Information;
   c. modify any Information without authority to do so;
   d. purge any Information without authority to do so.

9. I will log off, lock, or restart any computer prior to leaving it unattended.

10. I will inform my Medical Center point of contact, or other appropriate personnel of any known or suspected unauthorized disclosure or misuse of Information which I observe or of which I become aware.

11. I will protect Medical Center Information stored on a laptop computer by:
   a. Encrypting all Information stored on the laptop,
   b. Temporarily storing Information (during active use only) on the laptop, and
   c. Maintaining a current secure backup of all Information stored on the laptop (network, CD, DVD etc).

12. Any Information that I am authorized to store on removable storage media (e.g. CD's, DVD's, PDA's, USB/flash drives, external hard drives etc) will be store in a secure manner (that is, with password protection and/or encryption)

13. I will immediately report to my Medical Center point of contact if said media or any Information is ever lost or stolen.

14. I will secure (encrypt) all transmissions (email, file transfers, etc) that contain Confidential Information in accordance with the Medical Center Information Security and Privacy Policies.

15. I understand that public (i.e. non- Medical Center) wired and wireless networks should not be considered secure for any reason. Therefore, whenever I am connected to a computer network other than the Medical Center's conducting Medical Center business, I will use the Medical

Center's Portal (https://portal.wfubmc.edu) or VPN (Virtual Private Network) software to access the Medical Center's resources remotely.

16. I understand and agree that this Agreement shall be governed by and construed in accordance with the laws of the State of North Carolina and any claim or dispute arising from the terms or performance of this Agreement will be submitted to the jurisdiction of the state or federal courts of North Carolina, and I consent to the exclusive jurisdiction of such Courts.

17. I understand that any violation of the terms of this agreement may result in termination of my relationship with the Medical Center and/or termination of my access to Medical Center information and/or the Medical Center facility as applicable. I further understand that all of my computer activity, including e-mail and Internet use, is subject to auditing or monitoring by the Medical Center.

I acknowledge that I have read this agreement, understand its terms, and agree to abide by both this agreement and the Medical Center's Information Security and Privacy Policies and all other policies in effect where applicable concerning the security and privacy of Information.

I further understand and acknowledge that nothing contained in this agreement creates a contract regarding the term of my relationship with the Medical Center, express or implied.

☐ By checking this box, I acknowledge that I have read and understand this agreement.

Name: _____

Date: _____

[i] * *Unauthorized inquiries or transmissions include, but are not limited to, reviewing, removing, printing, and/or transferring Information from any Medical Center computer or paper filing systems to unauthorized locations, e.g. home computer, personal laptop, USB drives, CD/DVD, or other portable media.*

Direct any questions concerning this agreement to the Medical Center Privacy Office 336-713-HIPA

Wake Forest University Baptist Medical Center
NON-PATIENT PHOTO RELEASE FORM*

I hereby grant Wake Forest University Baptist Medical Center ("WFUBMC") and its agents, as well as any news media or company working in collaboration with a department of WFUBMC, permission to use my likeness in a photograph (still, film, or video) in any and all of its publications, including print, website entries, or other public media, without payment or any other consideration.

I understand and agree that these materials will become the property of WFUBMC and will not be returned.

I hereby irrevocably authorize WFUBMC to edit, alter, copy, exhibit, publish, or distribute this photo for purposes of publicizing WFUBMC or for any other lawful purpose. I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photograph.

I hereby hold harmless and release and forever discharge WFUBMC from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization or any use of the photograph.

I am at least 18 years of age and am competent to contract in my own name. I have read this release before signing below and I fully understand the contents, meaning, and impact of this release.

Print Name: _____

Signature: _____ Date: _____

If the person signing is under age 18, there must be consent by a parent or guardian, as follows:

I hereby certify that I am the parent or guardian of _____, named above, and do hereby give my consent without reservation to the foregoing on behalf of this person.

Parent/Guardian Print Name: _____

Parent/Guardian Signature: _____ Date: _____

***NOTE: If photo depicts treatment, payment, or health care, use form MR 08/04, <u>Authorization for Multi-Media Use and Disclosure of Protected Health Information</u>.**