



# MYLF

## Montana Youth Leadership Forum

### MYLF MINI APPLICATION

Applying: \_\_\_\_\_

Applying: \_\_\_\_\_

Applying: \_\_\_\_\_

Applying: \_\_\_\_\_

#### **LIBBY**

**April 16-17, 2020**

Venture Inn  
1015 9th St.  
Libby, MT 59923

#### **GLASGOW**

**April 23-24, 2020**

Cottonwood Inn  
54250 US-2  
Glasgow, MT 59230

#### **MILES CITY**

**May 4-5, 2020**

Miles City Hotel  
1615 S Haynes Ave,  
Miles City, MT 59301

#### **SIDNEY**

**May 6-7, 2020**

Holiday Inn Express  
251 W Holly St.  
Sidney, MT 59270

Students will check in at 10:00 a.m. and will be done at 2:00 p.m. the following day. All appropriate expenses for the forum will be covered including lodging, meals, training materials, and appropriate mileage will be reimbursed.

\*Please complete all information for this application in blue or black ink.

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**1. First Name** **Middle** **Last**

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**2. Address** **City** **Zip**

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**3. Male / Female** **4. Phone**

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**5. Name of High School** **6. Grade Level (as of Dec 31 2019)**

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**7. Your E-Mail Address** **8. Birth date (mm/dd/year)**

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**9. Date Graduation Expected** **10. Social Security Number**

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**11. Your Ethnicity** **12. Shirt Size (standard adult unisex sizing)**

**13. Please describe your disability.** This information will assist in assuring that we include delegates with a diversity of disabilities.

**Disability** (medical diagnosis) \_\_\_\_\_

**Onset/diagnosis of disability:** \_\_\_\_\_

**Check all that apply:**

Deaf _____	Developmental Disability _____
Hard of Hearing _____	Describe _____
I use sign language _____	Traumatic Brain Injury _____
I use real time captioning _____	Autism _____
I use lip reading _____	Other _____

Blind _____	Mental Health Disability _____
Visual Impairment _____	Neuromuscular Disability _____
I read with Braille _____	
I read with large print _____	

Orthopedic Disability _____	Learning Disability _____
I use a wheelchair _____	
I cannot walk upstairs _____	Multiple Disabilities _____
I cannot walk long distances _____	

Allergies	
_____ No known allergies	_____ Delegate is allergic to
	_____ Food
	_____ Medicine
	_____ Environmental factors

\*If the delegate has allergies please explain: \_\_\_\_\_  
\_\_\_\_\_

**Diet / Nutrition**

\_\_\_\_\_ Delegate eats a regular diet                      \_\_\_\_\_ Delegate eats a regular vegetarian diet

\_\_\_\_\_ Delegate has special food needs – please explain below  
\_\_\_\_\_

**Restrictions**

\_\_\_\_\_ I have reviewed the program information and feel the delegate can participate without restrictions.

\_\_\_\_\_ I feel the delegate can participate with the following restrictions or accommodations. Please explain needed accommodations (including any need for a personal care attendant):

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**Medication:**

\_\_\_\_\_ Delegate will not take any daily medications while attending.

\_\_\_\_\_ Delegate will take the following daily medication(s):

***"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies.***

Name of medication \_\_\_\_\_  
Date started \_\_\_\_\_  
Reason for taking it \_\_\_\_\_  
When it is given \_\_\_\_\_  
Amount or dose given \_\_\_\_\_  
How it is given: \_\_\_\_\_  
Assistance Needed: \_\_\_\_\_

Name of medication \_\_\_\_\_  
Date started \_\_\_\_\_  
Reason for taking it \_\_\_\_\_  
When it is given \_\_\_\_\_  
Amount or dose given \_\_\_\_\_  
How it is given: \_\_\_\_\_  
Assistance Needed: \_\_\_\_\_

\*please use additional paper if needed to list all medications accurately  
\* MYLF Staff is unable to administer medication, only offer reminders to take medication to delegates.

**Non-prescription medications may be stocked in the MYLF medical kit and are used on an as needed basis to manage illness and injury.**

***Cross out those items the delegate SHOULD NOT be given.***

- Acetaminophen (Tylenol)
- Ibuprofen (Advil, Motrin)
- Generic cough drops
- Antibiotic cream
- Calamine lotion Aloe
- Laxatives for constipation (Ex-Lax)
- Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

**General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers**

Has/does the delegate:

1. Ever been hospitalized?  Yes  No
2. Had fainting or dizziness?  Yes  No
3. Ever had surgery?  Yes  No
4. Passed out/had chest pain during exercise?  Yes  No
5. Have recurrent/chronic illnesses?  Yes  No
6. Had mononucleosis ("mono") during the past 12 months?  Yes  No
7. Had a recent infectious disease?  Yes  No
8. If female, have problems with periods/menstruation?  Yes  No
9. Had a recent injury?  Yes  No
10. Have problems with falling asleep/sleepwalking?  Yes  No
11. Had asthma/wheezing/shortness of breath?  Yes  No
12. Ever had back/joint problems?  Yes  No
13. Have diabetes?  Yes  No
14. Have a history of bedwetting?  Yes  No
15. Had seizures?  Yes  No
16. Have problems with diarrhea/constipation?  Yes  No
17. Had headaches?  Yes  No
18. Have any skin problems?  Yes  No
19. Wear glasses, contacts, or protective eyewear?  Yes  No
20. Traveled outside the country in the past 9 months?  Yes  No

Explain "Yes" answers: \_\_\_\_\_

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**Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.**

Has the delegate:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?  Yes  No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?  Yes  No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?  Yes  No
4. Had a significant life event that continues to affect the delegate's life?  Yes  No  
(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

*Please explain "Yes" answers in the space below, noting the number of the questions.*

\_\_\_\_\_

\_\_\_\_\_

**Health Care Provider:**

Name of Delegate's primary doctor(s): \_\_\_\_\_

Phone: \_\_\_\_\_

Name of dentist(s): \_\_\_\_\_

Phone: \_\_\_\_\_

**Parent/Guardian Authorization for Health Care:**

This health history is correct and accurately reflects the health status of the delegate to whom it pertains. The person described has permission to participate in all Mini Forum activities except as noted by me and/or an examining physician. I give permission to the physician selected by the MYLF to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with MYLF staff. I give permission to photocopy this form. In addition, MYLF has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian:

Relationship to Delegate: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent/Guardian with legal custody to be contacted in case of injury or illness**

Name: \_\_\_\_\_

Relationship to Delegate: \_\_\_\_\_

Preferred Phone Number: \_\_\_\_\_

E-Mail: \_\_\_\_\_

**Second parent/guardian or emergency contact**

Name: \_\_\_\_\_

Relationship to Delegate: \_\_\_\_\_

Preferred Phone Number: \_\_\_\_\_

E-Mail: \_\_\_\_\_

**13. Information on Vocational Rehabilitation**

If you are currently a client of Vocational Rehabilitation, please tell us your Counselor's Name \_\_\_\_\_

#### 14. School and Community Involvement

Below, please briefly list your involvement with your school and community. This may include any offices held, club memberships, after school activities or work experience.

<u>Activity</u>	<u>Adult Contact</u>	<u>Dates Involved</u>	<u>Grade</u>
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#### 15. Letters of recommendation

Please attach at least one letter of recommendation which describes your demonstrated leadership skills or your leadership potential.

List name, position/title, organization and telephone number of your Recommendation/s.

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#### 16. Personal Statement

Your answers to the following questions will be used to assess your readiness to participate in the Leadership Forum. Please write your responses on a separate sheet of paper and attach to your completed application packet.

- A. Qualifications – explain why you feel you are qualified to be a delegate to this forum and please tell us why you want to attend.
- B. Positive Influences – In terms of leadership, please tell us about two people who have positively influenced your life. Why? (Families, teachers, counselors, friends, public officials, or celebrities are appropriate examples).
- C. Experiences as a person with a disability – Describe two important experiences you have had as a person with a disability. (Please be specific about your examples as they relate to your disability.)
- D. Future Plans – Describe any of your plans for after high school.

**Request Form for Pre-Employment Transition Services  
Montana Vocational Rehabilitation and Blind Services**

Student Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address \_\_\_\_\_ Phone number: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ School ID Number: \_\_\_\_\_

Student's Race:  American Indian  Asian  Black  Native Hawaiian  White

Student's Ethnicity:  Hispanic or Latino  Not Hispanic or Latino

Student's Disability Status:  504 Accommodation  IEP  Has a Disability (No 504 or IEP)

Primary Disability: \_\_\_\_\_

School Name: \_\_\_\_\_ School Contact \_\_\_\_\_:

Student's Grade Level: \_\_\_\_\_ Expected Graduation Date: \_\_\_\_\_

Pre-Employment Transition Services Requested: (See Definitions and Check all that apply)

- Job Exploration Counseling
- Work Based Learning
- Counseling on comprehensive transition or postsecondary educational programs
- Workplace readiness training
- Instruction in self-advocacy

By signing this form, I am requesting Pre-Employment Transition Services. I understand that if I wish to apply for vocational rehabilitation services, I may do so at any time. For the specific purpose of participation in Pre-Employment Transition Services, I grant permission for Vocational Rehabilitation and Blind Services (VRBS) to exchange information with my school and service providers. I understand that VRBS requests my Social Security Number for federal reporting purposes. All information will be kept in the strictest confidence and used solely for program purposes. Information that I have provided is to the best of my knowledge true, correct and complete.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Student's Parent or Legal Guardian  
(if student is under 18)

\_\_\_\_\_  
Date

# Request Form for Pre-Employment Transition Services Montana Vocational Rehabilitation and Blind Services

## Student with a Disability Verification

**Definition:**

A student with a disability is an individual with a disability in a secondary, postsecondary, or other recognized education program who is not younger than 14 and not older than 21. The student is eligible for, and receiving, special education or related services under Part B of the Individuals with Disabilities Education Act (20 U.S.C. 1411 et seq.); or is an individual with a disability, for purposes of section 504; or is an individual with a disability who is not receiving a 504 accommodation or services under an Individualized Education Program (IEP).

**If this request form is being completed by school personnel, please verify the following:**

By signing this form, I verify that this individual meets the definition of a student with a disability and there is available documentation supporting that the student is:

- A student with a disability for the purposes of section 504; or
- A student with a disability and is receiving transition services under an Individualized Education Program (IEP); or
- A student with a documented disability who is not receiving a 504 accommodation or services under an Individualized Education Program (IEP).

School Personnel Name: \_\_\_\_\_  
(Printed)

\_\_\_\_\_  
(Signature) Date: \_\_\_\_\_

**If this request form is being completed by non-school personnel, one of the following supporting documents must be included with the submitted request form:**

- Copy of Individualized Education Program (IEP) or 504 Accommodation
- School records/statement from school personnel
- Proof of receipt of SSI/SSDI benefits based on individual's own disability
- Medical or psychological documentation signed by a licensed professional

**VRBS Office Use Only:**

- Required verification has been reviewed and individual is confirmed to be a student with a disability
- The student has reviewed information about the available Pre-ETS and requested specific services.
- VRBS is in agreement that the requested Pre-Employment Transition Services are appropriate and necessary for the student to prepare for life after high school.

VRBS Staff Name: \_\_\_\_\_ / \_\_\_\_\_ Date: \_\_\_\_\_  
(Printed) (Signature)





## Montana Youth Leadership Forum

### RELEASE AND WAIVER

I, \_\_\_\_\_ give permission for photographs/video footage of my child, \_\_\_\_\_ to be used by the Montana Youth Leadership Forum to promote the program. This may be in the form of brochures, posters, promotional videos, or academic or promotional presentations.

Furthermore, I release and hold Montana Youth Leadership Forum harmless from any liability from any act or omission, which arises from the use of the photographs/video(s). In addition, I waive any proprietary interest in the pictures/video(s) or any benefits whatsoever occurring to Montana Youth Leadership Forum of their use of such pictures/video(s).

I acknowledge by signing this release and waiver form that I fully understand its meaning and intent and I certify that I have the authority to grant all permissions, releases, and waivers herein granted.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**KEEP THIS PAGE –  
DO NOT RETURN WITH APPLICATION**

**Please use the checklist below to make certain your application packet is complete. All questions must be answered and requested letters and information provided.**

- Completed application form (*pages 1-6*)
- One letter of recommendation
- Personal statement responding to four topics (*listed on page 6*)
- Release and Waiver Form (*page 9*)
- Request Form for Pre-Employment Transition Services (*page 7*)
- Disability Verification form (*page 8*)

**Mail Completed Applications to:**

**MYLF**

**1617 Euclid Ave. Suite 1**

**Helena, MT 59601**

**or applications may be faxed to 406-443-3796.**

**Signed electronic applications will also be accepted to [JKHermanson@ncils.org](mailto:JKHermanson@ncils.org)**

**HOW STUDENT DELEGATES WILL BE SELECTED AND APPLICATION  
INSTRUCTIONS FOR STUDENTS.**

1. To be eligible for the Montana Youth Leadership Forum for Students with Disabilities, students must:
  - a. Have a disability (as defined by the ADA)
  - b. Be in the 8, 9, 10, 11, or 12<sup>th</sup> grade as of December 31, 2018
  - c. Must have demonstrated leadership potential in school and community
  - d. Reside in Montana
2. Student applicants must mail the completed Mini application packet to the MYLF office no later than 7 days before the start of the Mini.
3. Selected applicants will be notified no later than 4 days before the start of the Mini.
4. **All appropriate expenses will be paid by the Montana Youth Leadership Forum (MYLF)** including such expenses as travel, lodging, food, and interpreters for students who are deaf and personal assistants for students with physical disabilities.