

**Westchester County Board of Health**  
**J.R. Tesone Youth Public Health Service Award**

**2018 YOUTH NOMINATION FORM**

**CRITERIA:** A nominee should be a student whose volunteer efforts have made a creative contribution to public health in Westchester

**FILING DEADLINE:** **February 19, 2018**

**MAIL OR DELIVER TO:** Westchester County Board of Health  
 Public Health Awards  
 C/o Caren Halbfinger  
[Cqh4@westchestergov.com](mailto:Cqh4@westchestergov.com) Subject Line: 2018 Youth Nomination  
 Westchester County Department of Health  
 145 Huguenot Street, 7<sup>th</sup> Floor  
 New Rochelle, New York 10801

**1. NOMINEE INFORMATION (Use N/A where not applicable) and email a color photo and the completed photo release form.**

Nominee's name and age	School attending, Grade
Address	Time spent on this initiative
Email	Phone
Funding Source	Partner Agencies

**1. PUBLIC HEALTH CONTRIBUTIONS: Use the reverse side of this form or attach your remarks to describe the creative effort of the nominee and the positive impact he/she has had on public health in Westchester, any obstacles, and how he/she overcame them. Include multimedia examples and links as needed.**

**2. PERSON MAKING THE NOMINATION**

Name	Agency (if applicable)
Address	Phone and email
Signature	Date

**PUBLIC HEALTH CONTRIBUTIONS OF NOMINEE**

[Empty rectangular box for text entry]



## PHOTO RELEASE FORM

Participant's Name: \_\_\_\_\_

I hereby authorize Westchester County Department of Health to publish the photographs and/or video taken of me and/or my child(ren), along with our names, for use in WCHD's printed publications, website, Facebook page and Twitter and to share with the public.

I acknowledge that my participation is voluntary and I will receive no financial compensation.

I further agree that my participation in any video, publication or website produced by Westchester County Health Department confers upon me no rights of ownership whatsoever. I release Westchester County Health Department and its employees from liability for any claims by me or any third party in connection with my participation.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

### Minor Children:

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

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

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

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

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

## FORMULARIO DE AUTORIZACIÓN DE LA FOTO

Nombre del participante: \_\_\_\_\_

Por la presente autorizo a Westchester County Departamento de salud para publicar las fotografías tomadas de mí o mi hijo (a), junto con nuestros nombres, para uso en publicaciones impresas por WCHD, en el website, página de Facebook y Twitter.

Reconozco que mi participación en publicaciones y Website producidas por el Departamento de salud del Condado de Westchester es voluntaria. Yo no recibiré ninguna compensación económica.

Además acepto que mi participación en cualquier publicación y website producida por el Departamento de salud del Condado de Westchester no confiere sobre mí ningún derecho de propiedad alguna. Yo libero a Westchester County Health Department y sus empleados de responsabilidad por cualquier reclamación por mí o cualquier tercero en relación con mi participación.

Firma: \_\_\_\_\_ Fecha: \_\_\_\_\_

Dirección residencial: \_\_\_\_\_

Ciudad, Estado, Código postal: \_\_\_\_\_

### Niños Menores:

Nombre: \_\_\_\_\_ Edad: \_\_\_\_\_

Nombre: \_\_\_\_\_ Edad: \_\_\_\_\_

Nombre: \_\_\_\_\_ Edad: \_\_\_\_\_

Nombre: \_\_\_\_\_ Edad: \_\_\_\_\_

Nombre: \_\_\_\_\_ Edad: \_\_\_\_\_

DEPARTMENT OF HEALTH