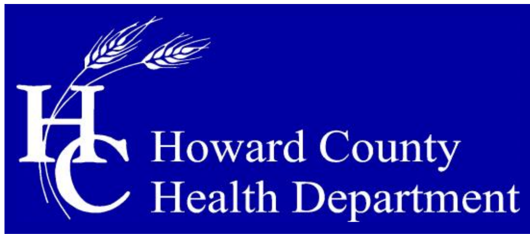

Cancer Prevention & Treatment
8930 Stanford Boulevard, Columbia, MD 21045
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TDD 410-313-2323 | Toll Free 1-866-313-6300
www.hchealth.org
Facebook: www.facebook.com/hocohealth
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Maura J. Rossman, M.D. Health Officer

Adolescent Smoking Awareness Program (ASAP) Referral Form

Student Name (last, first, middle): ______________________________

Home Address: ______________________________ Race: __________ DOB_________

Referred by:______________________ Date:___________ School: ______________________

☐ First Referral ☐ Second Referral ☐ Others ______________

Name of Parent/Guardian: ______________________________

Student contact information: (home) ________________ (cell) ________________

Text Available? Yes: ☐ No: ☐ E-mail address: ______________________________

Guardian/Parent contact information: (home) ________________ (cell) ________________

Text Available? Yes: ☐ No: ☐ E-mail address: ______________________________

Please read and sign acknowledgement of the Terms of Agreement:

- Students must be prompt. **No student will be allowed to enter classroom once the class has begun.**
- Any students asked to leave the class as a result of disruptive behavior will be sent home and will not be permitted to return.
- **Students must be picked up promptly after dismissal**
- **All** nicotine products are prohibited on the Howard County Health Department grounds.
- HCPSS **dress code** must be followed. Students failing to do so will not be allowed to attend class.
- Student **confidentiality** must be protected. No personal information disclosed in class is to be shared outside of class.
- All Facilitators are to follow HIPPA Privacy Regulations.
- A completed program consists of 4 classes, once weekly for 4 weeks. **If for any reason classes are missed, students will be required to make-up missed classes and complete an additional assignment.**
- Certificates of attendance will be issued after completion of 4 classes.

I, ________________________, acknowledge and agree to terms of agreement set forth by the Howard County Health Department in order to participate in the Adolescent Smoking Awareness Program.

Student Signature: ________________________ **Date:** ____________________

I, ________________________, acknowledge and agree to the terms of agreement set forth by the Howard County Health Department. I also acknowledge that my son/daughter is voluntarily attending the Adolescent Smoking Awareness Program and will assure their attendance in all classes.

Parent/Guardian Signature: ________________________ **Date:** ____________________

I, ________________________, acknowledge that ________________________ has successfully completed

____________ contact hours of Tobacco education.

HCHD Facilitator: ________________________ **Date**: ____________________