Delta Academy Participant Name _____

Delta Academy 2019 - 2020 Parent/Guardian Forms

* This document must be completed and signed by the participant's parent/guardian. This packet must be turned to one of the Delta Academy General Co-chairs as part of participation in the Delta Academy 2019 - 2020 program as a participant.

Delta Sigma Theta Sorority, Incorporated- Kansas City (MO) Alumnae Chapter

PARENTAL/GUARDIAN AFFIRMATION

I, _____, hereby give my permission to the Kansas City (MO) Alumnae Chapter of Delta Sigma Theta Sorority, Incorporated for _____ to participate in the Delta Academy 2019 - 2020 youth initiative (including planned activities), and I hereby attest, under penalty of perjury, that I have the legal authority to authorize such participation.

Printed Name: _____

Signature: _____

Relationship to child: _____

Date: _____

WAIVER AND RELEASE

I, _____, Parent/Guardian, on behalf of _____ ("Participant Minor Child") do hereby release, waive, discharge, covenant not to sue and agree to hold harmless Delta Sigma Theta Sorority, Incorporated ("DST"), its officers, National Executive Board, employees, members, local Chapters, representatives, agents, affiliates, and assigns (collectively "Releases"), from any and all claims, demands, and actions of any and every kind directly or indirectly arising out of, or relating in any respect to Participant Minor Child's participation in the_____Youth Initiative.

My waiver and release of all claims, demands, actions, and liability shall include without limitation, any injury, illness, death, property damage or loss to the Participant Minor Child which may be caused by any act, or failure to act, by the Releases, unless such injury, illness, death, property damage or loss is a direct result of the willful misconduct of any Releases.

I understand that, without limitation of the foregoing, neither Delta, nor the Program, shall be liable and each is hereby released from all claims that may arise from loss or damage to the Participant Minor Child's personal property.

Parent/Guardian Signature: _____

Date: _____

Delta Sigma Theta Sorority, Incorporated- Kansas City (MO) Alumnae Chapter

PHOTOGRAPH, MEDIA AND VIDEO AUTHORIZATION RELEASE FORM

I/We,_____("Parent/Guardian"), as parent(s) or legal guardian(s) of_____, give permission for Kansas City (MO) Alumnae Chapter of Delta Sigma Theta Sorority, Incorporated (the "Chapter") to publish on the Internet or media still photographs or moving images, including, if applicable any sound recordings accompanying the images ("Images") taken of my child during participation in Delta Academy 2019 - 2020 Youth Initiative Program activities, without payment or any consideration and without notifying me in advance.

I/We also give permission for the Chapter to highlight my child's achievements and activities in efforts to promote the youth initiative program through newspapers, radio, TV, the web, DVDs, displays, brochures, and other types of media without payment or any consideration and without notifying me.

I/We understand and agree that these Images will become the property of the Chapter, which shall have complete ownership of the Images. I hereby irrevocably authorized the Chapter to publish or distribute these Images for the purpose of publicizing the Chapter's programs, including the Delta Academy 2019 - 2020 Youth Initiative Program or for any other lawful purpose. In addition, I waive any right to inspect or approve the finished product wherein my child's likeness appears. Additionally, I waive any rights to royalties or other compensation arising out of or related to the use of the Images.

I/We hereby hold harmless and release and forever discharge the Chapter and any of its officers and members; Delta Sigma Theta Sorority, Incorporated; its officers; National Executive Board; employees; members; representatives; agents; and assigns from any and all claims, costs, suits, actions, judgments, and expenses which my child, his/her heirs, representatives, executors, administrators, or any other persons acting on his/her behalf have or may have by reason of the use of the Images. This release specifically includes, without limitation, a complete release and discharge of any liability by virtue of any editing, distortion, alteration, or optical illusion, whether intentional or otherwise, that may occur or be produced in the taking of or editing of said Images, unless it can be shown that such was maliciously caused, produced and published solely for the purpose of subjecting my child to conspicuous ridicule, scandal, reproach, scorn and indignity.

I/we hereby certify that I/we are the parents/guardians of_____, authorized legally to give this consent, and do hereby give my/our consent without reservation to the foregoing on behalf of my/our child.

_____ _____

Parent/Guardian Signature Date

_____

Print Name

_____ _____

Parent/Guardian Signature Date

_____

Print Name

YOUTH CODE OF CONDUCT

1. Respect all participants (other youth and adult volunteers) by not using foul, hurtful or obscene language or engaging in physical violence, bullying (including cyber-bullying)[1] or other aggressive behaviors that threaten the safety of others.
2. Respect the property rights of others. This means do not damage or deface the building or property within the building where chapter activities are held; do not damage or take the personal property of any other participant or volunteer; and do not use Delta's name or any symbol or logo (Delta's intellectual property) on any clothing, books, bags, or other items.
3. Return supplies to their proper place after using them.
4. Clean up all work areas properly.
5. Listen carefully to directions and when someone else is talking.
6. Respect designated quiet areas, such as homework/reading area.
7. Stay within the program's designated areas within the building.
8. Cooperate and participate in organized activities.
9. Assume full responsibility for all personal belongings. Please leave valuables at home.
10. Do not bring any weapons, cigarettes/drugs, alcohol, or anything illegal to any activity at any time.

Sanctions for Violating *Code of Conduct*

Bad Language/Abusive Teasing and Related Acts:

1st Time: Verbal warning, *parent or guardian notified from this point forward*
2nd Time: Loss of privileges
3rd Time: 1-week suspension from program
Next occurrence youth is removed from the program.

Physical Violence and Other Misconduct:

1st Time: Removal from situation, loss of privileges, *guardian notified from this point forward*
Next occurrence youth is removed from the program.

Illegal Substances or Dangerous Weapons

1st Time: Youth is removed from the program. If a youth is in possession of an illegal substance or dangerous weapon, the police will be notified as well.

[1] Cyber-bullying is defined in Appendix C4, which sets out the *Internet Use Policy*.

Delta Sigma Theta Sorority, Incorporated- Kansas City (MO) Alumnae Chapter

(Student Participant)

With my parent or other adult, I have read the *Code of Conduct* and sanctions for violating the Code. I understand the Code and the sanctions. I will follow the *Code of Conduct*.

_____ _____

Signature Date

_____

Print Name

****

(Parent)

I have read and understand the *Code of Conduct* and sanctions for violating the *Code of Conduct*. I understand that my child's compliance with the *Code of Conduct* is a condition of her/his participation in the Delta Academy 2019 - 2020 program. I agree that the sanctions for violating the *Code of Conduct* are reasonable and will help my child comply.

_____ _____

Signature Date

_____

Print Name

Delta Sigma Theta Sorority, Incorporated- Kansas City (MO) Alumnae Chapter

YOUTH PICK-UP AUTHORIZATION FORM

I authorize the persons listed below to pick-up my child from the_____youth initiatives program. For my child's safety, I understand that all authorized persons on the list below will be asked to show photo identification before my child is released to them; therefore, I will notify all authorized persons of this requirement so that they will have photo identification with them when they arrive to pick-up my child. (*Please include names of either parents or guardians on list below).*

Name_____Relationship _____

Home Phone_____Work Phone_____Cell Phone _____

Name_____Relationship _____

Home Phone_____Work Phone_____Cell Phone _____

Name_____Relationship _____

Home Phone_____Work Phone_____Cell Phone _____

Name_____Relationship _____

Home Phone_____Work Phone_____Cell Phone _____

Name_____Relationship _____

Home Phone_____Work Phone_____Cell Phone _____

By signing below, I verify that I have read and agree to the Student Pick-Up policies described above and authorize the Kansas City (MO) Alumnae Chapter to release my child to the persons listed above. I also agree to notify the Kansas City (MO) Alumnae Chapter in writing of any changes to the above list of authorized persons.

Mother/Guardian Signature_____Date _____

Father/Guardian Signature_____Date _____

MEDICAL INFORMATION AND TREATMENT AUTHORIZATION PACKET

Today's Date: _____

Name of Minor: _____ Date of Birth: _____

Age: _____

Address: _____

City/State/Zip Code: _____

Parent/Guardian Home Phone: _____

Cell Phone: _____ E-mail Address: _____

Minor's Gender: _____ Height: _____ Weight: _____

HEALTH INFORMATION

Below please check any current health condition that may require attention during the Program day. Also complete and submit the Medication Authorization Form if your child has health conditions that require medication during the Program day.

Asthma Inhaler required at Program: ☐ Yes or ☐ No

Vision Problems: ☐ Glasses ☐ Contacts

Hearing Problems: ☐ Hearing Aid(s)

ADD/ADHD: ☐ Yes or ☐ No

Other:

_____

Allergies/Sensitivities (be specific)

Foods _____

Medicines _____

Bee sting or insect bite _____ Other _____

List all medications and dosages your child receives on a continual basis:

_____

_____

Health History:

Child's Name (Last, First, M.I.): _____

Gender (check one): Male_____Female ☐ DOB (mm/dd/yy): _____

Parent/Guardian Name:_____Does Parent/Guardian live in home with child? ____

Parent/Guardian Name:_____Does Parent/Guardian live at home with child? ____

Is/Has child been under the regular supervision of a physician? _____

Name, address, and phone number of physician _____

_____

Date of last physical exam: _____

Health and Developmental History:

Childhood illness: Check any that apply

☐ Measles ☐ Mumps ☐ Asthma ☐ Chickenpox

☐ Rheumatic Fever ☐ Hay Fever ☐ Diabetes ☐ Epilepsy

☐ Whooping Cough ☐ Poliomyelitis ☐ Ten-Day Measles (Rubella)

☐ Three-Day Measles (Rubella)

Other (please list): _____

Does child have any significant health history, conditions, communicable illness, or restrictions that may affect child's participation in the_____youth initiatives program?

(Check one) ☐ None ☐ Yes

If yes, please provide detailed explanation _____

_____

_____

Does child have any significant food/medication/environmental allergies that may require emergency medical care at the_____youth initiatives program?

(Check one) ☐ None ☐ Yes

If yes, please provide detailed explanation _____

_____

Specify any other serious or severe illnesses or accidents: _____

_____

Does child take prescribed medications? Name the medications: _____

_____

Frequency Taken:_____**(**For any medications or treatment required during the course of the _____ youth initiatives program, a Medication Authorization Form should be completed and submitted with this form.)

Does child take any over the counter medications frequently? ☐ Yes ☐ No

Name of the medications: _____

Frequency Taken: _____

NON-PRESCRIPTION MEDICATION PERMIT

PLEASE CHECK those medications you give permission for your child to receive (generic equivalent may be used). I/We understand that medications will be administered with discretion by an authorized Program employee and in accordance with established protocols developed by the Program.

The following nonprescription medications may be available to your child:

☐ **For headaches/fever/muscle aches/pain/cramps**: Acetaminophen (e.g., Tylenol, including Junior Strength), Ibuprofen (e.g., Advil, including Children's liquid, Motrin), Naproxen (Aleve), Midol, & Excedrin.

☐ **For bites/allergic rashes**: Anti-itching lotion (e.g., Calamine or Hydrocortisone cream 1%), Benadryl liquid or capsules.

☐ **For nasal congestion/sinus pressure**: Decongestant

☐ **For sore throat**: Throat lozenges (e.g., Capitol lozenges)

☐ **For coughs**: Cough drops/lozenges or cough suppressant.

☐ **For upset stomach**: Antacid liquid or chewable tablets (e.g., Mylanta)

☐ **For sun protection**: Sunscreen lotion SPF 30.

☐ **I DO NOT WANT ANY MEDICATIONS GIVEN TO MY CHILD.**

Parent/Guardian Signature_____Date_____

PHYSICIAN & INSURANCE INFORMATION

Name of Child's Physician_____ Phone _____

Health Insurance Company_____ Phone _____

Policy Number_____ Group Number _____

Insurance Company Address _____

City/State/Zip Code _____

Name of Policy Holder _____

Name of Policy Holder's Employer _____

EMERGENCY CONTACT INFORMATION

Parent/Guardian #1

Name_____Relationship_____

Street Address _____

City_____ State_____Zip Code _____

Home Phone_____Work Phone _____

Cell Phone_____ E-mail address _____

Parent/Guardian #2

Name_____Relationship_____

Street Address _____

City_____ State_____Zip Code _____

Home Phone_____Work Phone _____

Cell Phone_____ E-mail address _____

If for any reason I/we cannot be reached, please contact the following person(s) whom I/we hereby authorize to seek emergency medical or surgical care for my/our child.

Name:_____Relationship to Student _____

Home Phone_____ Work Phone _____

Cell Phone _____

Name:_____Relationship to Student _____

Home Phone_____ Work Phone _____

Cell Phone _____

In the event that the Program is unable to reach any of the individuals named above promptly by phone, I/we authorize the Program to seek and secure any emergency medical or surgical care for my/our child. I/We will be responsible for any and all expenses incurred and authorize the medical facility at which treatment is rendered to release all necessary information to my/our insurance company.

Parent/Guardian Signature_____Date _____

Parent/Guardian Signature_____Date _____

***The remaining pages only need to be completed if your child will be taking any prescription medicine during any events for Delta Academy 2019 - 2020.**

MEDICATION AUTHORIZATION FORM

(To be filled out by the physician dispensing the medication)

Name of Minor _____

Birthdate _____

Medication _____

Dosage _____

Time of administration _____

Reason for medication _____

Route of administration _____

Possible side effects and significant information _____

_____

_____

Physician's signature _____

Date _____

Physician's telephone number: _____

PARENTAL PERMISSION FORM
ADMINISTRATION OF PRESCRIPTION MEDICATION

I/We hereby give permission for_____to take_____ at the Delta Academy youth initiatives program as ordered by his/her physician identified above.

I/We understand that it is my/our Child's responsibility to report to one of the Delta Academy General co-chairs: Nola Faulkner or Tammie Williams at the appropriate time for the Administration of the medication.

I/We further understand that it is my/our responsibility to furnish this medication and any authorized refills. I/We further understand that Delta Sigma Theta Sorority, Incorporated ("DST"), its officers, National Executive Board, employees, members, local Chapters, representatives, agents, affiliates, assigns, the Delta Academy youth initiatives program, its agents, and/or any employee who administers any drug to my/our child, in accordance with written instructions from the prescriber, shall not be liable for damages as a result of an adverse drug reaction or any other injury suffered by my/our child due to the administration or failure to provide the drug.

The Delta Academy youth initiatives program reserves the right to refrain from administering medication if in the judgment of the Delta Academy 2019 - 2020 youth initiatives program, or other authorized Program officer, agent, or employee the circumstances do not warrant medication administration.

I/We understand that the medication must be brought to the Delta Academy youth initiatives program by me/us in the original appropriately labeled container.

If I/we cannot bring the medication to the Delta Academy youth initiatives program, I/we will call the Delta Academy youth initiatives program to inform them that my/our child will be bringing it, indicating the amount of medication in the container.

Parent/Guardian's Signature_____ Date _____

MEDICATION ADMINISTRATION PROCEDURES

Prescription Medication

1. We require the Medication Authorization Form to be completed by the prescribing physician and the parent. For each prescription medication ordered, the physician must give the following information: (1) the student's name, (2) the medication, (3) the dosage, (4) the time of administration, (5) the reason for administration, (6) the route of administration, (7) the possible side effects, and (8) any other significant information. The form must then be signed and dated by the prescribing physician. Signed parental consent is also required for each medication. This consent releases Delta Sigma Theta Sorority, Incorporated, the Delta Academy youth initiatives program, and their officers, National Executive Board, employees, members, local Chapters, representatives, agents, affiliates, and assigns from liability if the medication causes adverse reactions. The Medication Authorization Form is updated annually.
2. The original prescription container must accompany all medication to be given at the Delta Academy youth initiatives program. Medications should be brought to the Delta Academy youth initiatives program by the parent or responsible adult and taken to one of the Delta Academy General co-chairs: Nola Faulkner or Tammie Williams. The original prescription container should be labeled with the following information: name of student, name of medication, dosage of medication to be given, frequency of administration, route of administration, name of physician ordering medication, date of prescription, and expiration date.
3. If possible, the parent should provide the number of days' worth of the medication if it is to be given every day. It is the parent's responsibility to provide adequate refills on a timely basis.
4. All medication is kept in a locked cabinet or locked container at all times. If not retrieved by a parent or responsible adult, all medication will be destroyed one week after the expiration date or at the end of the term for the Delta Academy youth initiatives program.
5. A record will be maintained every time a medication is given. The record includes the student's name, date, time of administration, and dosage.

Over-the-Counter Medication

1. Written parental/guardian consent for the administration of over-the-counter medication is obtained through the emergency forms.[1]
2. A record will be maintained every time a medication is given. The record includes the student's name, date, time of administration, and dosage.

[1] A copy of the Medical Treatment Authorization is attached hereto as Appendix B