

**Dr. Betty Shabazz Academy
Parent/Guardian Forms**

PARENTAL/GUARDIAN AFFIRMATION

I, _____ hereby give my permission to the Indianapolis Alumnae Chapter of Delta Sigma Theta Sorority, Incorporated for _____ to participate in the Dr. Betty Shabazz Youth Academy (the "Program") (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 Dr. Betty Shabazz Youth Academy (the "Program").

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: _____

PHOTOGRAPH, MEDIA AND VIDEO AUTHORIZATION RELEASE FORM

I/We, _____ (“Parent/Guardian”), as parent(s) or legal guardian(s) of _____, give permission for Indianapolis 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 Dr. Betty Shabazz Youth Academy (the "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 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 authorize the Chapter to publish or distribute these Images for the purpose of publicizing the Chapter’s programs, including the 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, members and volunteers; 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 includes, but is not limited to, the following misuses of technology: harassing, teasing, intimidating, threatening, or terrorizing another individual by way of any technological tool, such as sending or posting inappropriate or derogatory email messages, instant messages, text messages, digital pictures or images, or website postings which has the effect of: physically, emotionally or mentally harming an individual; placing an individual in reasonable fear of physical, emotional or mental harm; placing an individual in reasonable fear of damage to or loss of personal property; or creating an intimidating or hostile environment that substantially interferes with an individual's educational opportunities

(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 Program. I agree that the sanctions for violating the *Code of Conduct* are reasonable and will help my child comply.

Signature

Date

Print Name

YOUTH PICK-UP AUTHORIZATION FORM

I authorize the persons listed below to pick-up my child from the 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 Indianapolis Alumnae Chapter to release my child to the persons listed above. I also agree to notify the 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:

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

- | | | | |
|--|--|--|-------------------------------------|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Asthma | <input type="checkbox"/> Chickenpox |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Poliomyelitis | <input type="checkbox"/> Ten-Day Measles (Rubella) | |
| <input type="checkbox"/> 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 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 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 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 _____

MEDICATION AUTHORIZATION FORM

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

Name of Minor _____

Birth date _____

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 Program as ordered by his/her physician identified above.

I/We understand that it is my/our Child's responsibility to report to **LaToya Black** 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 Program, its agents, and/or any employee or volunteer 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 Program reserves the right to refrain from administering medication if in the judgment of the 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 Program by me/us in the original appropriately labeled container.

If I/we cannot bring the medication to the Program, I/we will call the 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 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 Program. Medications should be brought to the Program by the parent or responsible adult and taken to **LaToya Black**. 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 one 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 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 Medical Information and Treatment Authorization Packet.
 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.
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