North Arundel County Alumnae Chapter
Delta Sigma Theta, Sorority, Inc.
Youth Initiatives Program

PARENTAL AFFIRMATION

I, ___________________________________, Parent/Guardian, under penalty of perjury, do hereby affirm to the ***North Arundel County Alumnae*** Chapter of Delta Sigma Theta Sorority, Incorporated that I authorize the participation of ________________________, in the ____________________ youth initiatives program (including planned activities), and that I have the legal authority to provide my consent and authorization for such participation.

Printed Name: ___________________________________

Signature: _______________________________________

Date: ____

Relationship to child: ______________________________

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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 ("Delta"), 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 ___________________________ 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 Releasee, unless such injury, illness, death, property damage or loss is a direct result of the willful misconduct of any Releasee. 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: _________________________

CODE OF CONDUCT FOR YOUTH

PARTICIPATING IN YOUTH INITIATIVES PROGRAM

1. Respect all participants (other youths and adult volunteers) by not using foul, hurtful or obscene language or engaging in physical violence, bullying (including cyber-bullying) or other aggressive behaviors that threaten the safety of others.
2. Respect the property rights of other. 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-day suspension from program

4th 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*

2nd Time: 1-day suspension from program

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3rd Time: 1-week suspension from program

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.

*Cyber-bullying is defined in Appendix 16, which sets out the *Internet Use Policy*.

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*.

__________________________________ ______________________________

Parent Signature Participant Signature

Date______________________________

****

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.

___________________________________ _______________________________

Parent Signature Participant Signature

Date_______________________________

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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 North Arundel County Alumnae Chapter to release my child to the persons listed above. I also agree to notify the North Arundel County Alumnae Chapter in writing of any changes to the above list of authorized persons.

Mother/Guardian Signature ___________________________________Date _______________

Father/Guardian Signature ____________________________________Date _______________

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MEDICAL INFORMATION FORM

Today's Date: __________________________

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 regular supervision of a physician? _________________________________

Name and address 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 ____

____

____

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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? _______________

Name the medications: ____

Frequency Taken: ____

Does child have any allergies? _________________

Specify: ____

Does the student use any special device(s**)** (i.e. hearing aids, cochlear implants, etc.): ____________

Name the Device(s): ____

Reason for use: ____

EMERGENCY MEDICAL TREATMENT AUTHORIZATION

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.

Allergies/Sensitivities (be specific)

Foods____

Medicines____

Bee sting or insect bite____

Other____

_ Asthma _ Inhaler required at Program

_ Vision Problems _ Glasses _ Contacts

_ Hearing Problems _ Hearing Aid(s)

_ ADD/ADHD

_ Other

____

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

____

____

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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., Cepacol 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 ____

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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 ____________

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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____

Physician's telephone number ____

PARENTAL PERMISSION FORM

ADMINISTRATION OF PRESCRIPTION MEDICATION

I/We hereby give permission for ________________________________ to take _______________________________________at the _____________________________________ 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 _______________________ 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 ("Delta"), its officers, National Executive Board, employees, members, local chapters, representatives, agents, affiliates, assigns, the __________________________ 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 _______________________ youth initiatives program reserves the right to refrain from administering medication if in the judgment of the __________________________ 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 ________________________ youth initiatives program by me/us in the original appropriately labeled container. If I/we cannot bring the medication to the ______________________ youth initiatives program, I/we will call the _____________________ 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______________

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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, the ____________________________ 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 _________________________ youth initiatives program. Medications should be brought to the _________________________ youth initiatives program by the parent or responsible adult and taken to __________________. 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 _____ 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 _____________________________ 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 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. A copy of the Emergency Medical Treatment Authorization is attached hereto as Appendix 18.

PHOTOGRAPH AND VIDEO AUTHORIZATION AND RELEASE FORM

I/We, ____ ("Parent/Guardian"), as parent(s) or legal guardian(s) of _____________________________________, give permission for *North Arundel County 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 at _______________________ Youth Initiative Program on ___________________ (date of the event), 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 _________________________ 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 _______________________________, 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

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