

## **B. Parent/Guardian Forms**

**APPENDIX B1**

**PARENTAL/GUARDIAN AFFIRMATION**

I, \_\_\_\_\_, hereby give my permission to the \_\_\_\_\_ Chapter of Delta Sigma Theta Sorority, Incorporated for \_\_\_\_\_ to participate in the \_\_\_\_\_ 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: \_\_\_\_\_

**APPENDIX B2**

**PHOTOGRAPH, MEDIA AND VIDEO AUTHORIZATION RELEASE FORM**

I/We, \_\_\_\_\_ (“Parent/Guardian”), as parent(s) or legal guardian(s) of \_\_\_\_\_, give permission for \_\_\_\_\_ 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 \_\_\_\_\_ 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 \_\_\_\_\_ 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

## APPENDIX B3

### 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)<sup>1</sup> 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

1<sup>st</sup> 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.

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<sup>1</sup> Cyber-bullying is defined in Appendix C4, which sets out the *Internet Use Policy*.

**(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

**APPENDIX B4**

**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 \_\_\_\_\_ 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 \_\_\_\_\_

APPENDIX B5

**WAIVER AND PERMISSION TO TRANSPORT YOUTH**

Name of Child: \_\_\_\_\_

Event: \_\_\_\_\_

Location: \_\_\_\_\_

Driver: \_\_\_\_\_

I give permission for my child/charge ("child") to be transported in a motor vehicle driven by the individual identified to an event at the specified location on the date indicated. I understand that my child is expected to follow all applicable laws regarding riding in a motor vehicle and is expected to follow the directions provided by the driver.

I have read, understand, and discussed with my child that:

- (1) They will be traveling in a motor vehicle driven by an adult and they are to wear their safety-belt while traveling;
- (2) They are expected to respect the vehicles they ride in, and the person they travel with during the trip;
- (3) Riding in a motor vehicle may result in personal injuries or death from wrecks, collisions or acts by riders, other drivers, or objects; and
- (4) They are to remain in their seats and not be disruptive to the driver of the vehicle.

I recognize that by participating in this activity, as with any activity involving motor vehicle transportation, my child may risk personal injury or permanent loss. I hereby attest and verify that I have been advised of the potential risks, that I have full knowledge of the risks involved in this activity, and that I assume any expenses that may be incurred in the event of an accident, illness, or other incapacity, regardless of whether I have authorized such expenses.

As a condition for the transportation received, I, for myself, my child, my executors and assigns, further agree to release and forever discharge Delta Sigma Theta Sorority, Incorporated and the \_\_\_\_\_ Chapter from any claim that I might have myself or that I could bring on my child's behalf with regard to any damages, demands or actions whatsoever, including those based on negligence, in any manner arising out of this transportation. I have read this entire waiver and permission form, fully understand it, and agree to be legally bound by its terms.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

**APPENDIX B6**

**OFF-SITE PERMISSION**

I/We, \_\_\_\_\_ (“Parent/Guardian”), as parent(s) or legal guardian(s) of \_\_\_\_\_ (“Child”), give permission for my/our Child to participate in the \_\_\_\_\_ Youth Initiatives Program’s (the “Initiatives”) activities taking place off site. I/we understand that transportation to and from these activities will be provided for my/our Child by the Chapter.

I/We understand that the field trips are part of the Initiatives and if I/we choose to not have my/our Child participate in one or more off-site activities, I/we must make other care arrangements for my/our child during the times of that field trip activity.

I/We assume all risks and hazards of loss or injury of any kind that may arise in connection with such trips, except for gross negligence or intentional infliction of harm by the Initiatives, its officers, agents or employees.

I/We do hereby agree to release and hold harmless the Initiatives, 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 for any damage, loss, or injury to my/our child or damage to my/our child’s property arising from my/our child’s participation in field trips, other than damage, loss, or injury that results from gross negligence or intentional infliction of harm by the Initiatives, Delta Sigma Theta Sorority, Incorporated, its officers, National Executive Board, employees, members, representatives, agents and assigns.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name



**APPENDIX B7**

**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

- |  |  |  |                                     |
|--|--|--|-------------------------------------|
| <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 \_\_\_\_\_ 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 \_\_\_\_\_

**APPENDIX B8**

**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 \_\_\_\_\_ 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 ("DST"), 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 \_\_\_\_\_

## 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 \_\_\_\_\_ 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/guardian consent for the administration of over-the-counter medication is obtained through the emergency forms.<sup>1</sup>
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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<sup>1</sup>A copy of the Medical Treatment Authorization is attached hereto as Appendix B8.