DeSoto County (MS) Alumnae Chapter
Delta Sigma Theta Sorority, Inc.
P.O. Box 1844
Southaven, MS 38671

October 1, 2017

Dear Parent(s) or Guardian(s):

We invite young girls between the ages of 11 and 14 to participate in the Dr. Betty Shabazz Delta Academy, which is a national program, sponsored by Delta Sigma Theta Sorority, Inc., a public service sorority, to enhance the future of young girls in the 21st Century.

Delta Academy is designed for girls who demonstrate the potential to succeed, but may not have the necessary support systems in place, nor the encouragement necessary to help them believe that yes, they too, can excel in math, science, and technology, and be prepared to compete for the jobs of the future. The theme, ***"Delta Academy: Catching the Dreams of Tomorrow – Preparing Young Women for the 21st Century"*** embodies that thrust.

You are invited to attend the program kick-off which will be held on Saturday, November 18, 2017 at M.R. Davis Southaven Public Library, 8554 Northwest Drive, Southaven, MS 38671, at 4:30 P.M.

Delta Academy activities will be held on the 3rd Saturday of each month beginning January 20, 2018 from 10:00 AM to 12:00 pm at Horn Lake Public Library (unless otherwise notified).

Attached you will find the program application and other pertinent forms for you to complete. The application and forms must be signed and postmarked to the address above OR scanned and emailed back to dcac.**deltaacademy@gmail.com** no later than **November 4, 2017.**

Please don't hesitate to contact the Shawn Sipp-Young at dcac.deltaacademy@gmail.com with any questions you may have. We look forward to working with you and your young lady.

Best Regards,

E Darlene Williams

Shawn Sipp-Young

E Darlene Williams
Chapter President
DeSoto County (MS) Alumnae Chapter

Shawn Sipp-Young
Chair, Educational Development
DeSoto County (MS) Alumnae Chapter

Rev. 10/2017

Delta Sigma Theta Sorority, Inc.

DeSoto County Alumnae Chapter

E Darlene Williams, President

Delta Academy

Application for Participation

Name of Applicant: _____

Date of Birth: _____ Age: _____

This year will be my 1st 2nd 3rd 4th year participating in Delta Academy.
(circle one)

Address: _____

City: _____ State: _____ Zip Code: _____

Student E-Mail: _____

School: _____ Grade: _____

Please rate the following activities 1 to 5 (1 being least interesting and 5 being most interesting):

___ Etiquette Session ___ Real Life Budgeting ___ Career Fair
___ Self Esteem ___ HIV/Aids Awareness ___ Sleepover
___ Health and Beauty ___ Volunteering/Community Service

What are your favorite subjects in school?

_____ Math _____ Science _____ English _____ History _____ Computer

_____ Other: _____

Adult T-Shirt Size (circle one): S M L XL XXL

Parent or Guardian Information

Parent(s)/Guardian(s) Name: _____

Home Number: _____ Work Number: _____

Parent(s)/Guardian(s) Cell Number: _____

Parent(s)/Guardian(s) E-mail: _____ Rev. 10/2017

Child's Name: _____

Write a short statement explaining what you hope to gain from being a participant of Delta Academy (an additional sheet of paper may be used).

_____

_____

_____

_____

_____

Participant Commitment:

I agree that I will try my best to attend and fully participate in all scheduled Delta Academy sessions. I will have an open mind and will challenge myself to learn new things, meet new people and have a positive attitude at all times.

_____ _____

Delta Academy Participant Signature Date

Parent Commitment:

I agree that my child may participate in the Delta Academy program. I agree to make every effort to have her attend all scheduled Delta Academy sessions. I understand that transportation to and from Delta Academy sessions is not provided by DeSoto County (MS) Alumnae Chapter of Delta Sigma Theta Sorority, Inc. I agree to pick-up my child at the designated end-time for all Delta Academy sessions.

_____ _____

Parent(s)/Guardian(s) Signature Date

Please return this application to:

Shawn Sipp-Young
c/o Delta Academy
P.O. Box 1844
Southaven, MS 38671

Questions? E-mail: dcac.deltaacademy@gmail.com

Deadline for submitting an application is November 4, 2017 Rev. 10/2017

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.

___ Allergies/Sensitivities (be specific)

Foods_____

Medicines_____

Bee sting or insect bite_____

Other_____

___ Asthma __ Asthma Inhaler required at Program (Yes or No)

___ Vision Problems __ Glasses __ Contacts

___ Hearing Problems __ Hearing Aid(s)

___ ADD/ADHD (Yes or No)

___ Other _____

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

_____

_____

(Medical Information and Treatment Authorization Packet (Continues)

Health History:

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

Gender (Check one): Female ☐ Male ☐ DOB (mm/dd/year): _____

Parent/Guardian Name: _____Parent/Guardian live in home with child? ___

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

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

Name, address, and phone number of physician _____

_____

Date of last physician exam: _____

Health and Developmental History:

Childhood illness: Check any that apply

___ Measles ___Mumps ___Asthma ___ Chicken pox

___ 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 Delta Academy 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 care at the Delta Academy Youth Initiatives Program?
(Check one) ____ None ____ Yes

If Yes, please provide detailed explanation _____

_____

(Medical Information and Treatment Authorization Packet (Continues)
Child's Name: _____

Specific 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 Delta Academy 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 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_____

(Medical Information and Treatment Authorization Packet (Continues)

Child's Name _____

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

Child's Name _____

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 _____

PARENTAL PERMISSION FORM
ADMINISTRATION OF PRESCRIPTION MEDICATION

I/We hereby give permission for _____ to take _____ at the Delta Academy Youth Initiative 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 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 a drug.

The Delta Academy Youth Initiatives program reserves the right to refrain from administering medication if in the judgement of the Delta Academy Youth Initiatives Program, or other authorized Program officer, agent, or employee the circumstances do not warrant medication administration.

If I/we cannot bring the medication to the Delta Academy Youth Initiatives program, I/we will call the Delta Academy Youth Initiative 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

Child's Name: _____

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 _____ .
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 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.
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.

PARENTAL / GUARDIAN AFFIRMATION

I, _____, Parent/Guardian, under penalty of perjury, do hereby affirm to the DeSoto Alumnae Chapter of Delta Sigma Theta Sorority, Incorporated that I authorize the participation of _____, Participant Minor Child, in the Delta Academy 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: _____

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"/"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 Delta Academy 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

YOUTH CODE OF CONDUCT
(YOUTH INITIATIVES PROGRAM)

Child's Name _____

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-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.

Youth Code of Conduct (Continues)

(Student Participation):

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*.

_____ _____

Participant (Print Name) Signature

Date_____

(Parents):

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

_____ _____

Parent/Guardian (Print Name) Signature

Date_____

PHOTOGRAPH, MEDIA AND VIDEO AUTHORIZATION RELEASE FORM

I/We, _____ ("Parent/Guardian"), as parent(s) or legal guardian(s) of _____, give permission for DeSoto County (MS) 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 the Delta Academy Youth Initiative Program without payment or any consideration and without notifying me in advance.

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 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 PICK-UP AUTHORIZATION FORM

Child's Name:_____

I authorize the persons listed below to pick-up my child from the Delta Academy Youth Initiative Program (DeSoto County (MS) Alumnae Chapter. 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 _____

Cell Phone _____ Home Phone_____ Work Phone _____

Name_____ Relationship _____

Cell Phone _____ Home Phone_____ Work Phone _____

Name_____ Relationship _____

Cell Phone _____ Home Phone_____ Work Phone _____

Name_____ Relationship _____

Cell Phone _____ Home Phone_____ Work Phone _____

Name_____ Relationship _____

Cell Phone _____ Home Phone_____ Work Phone _____

By signing below, I verify that I have read and agree to the Student Pick-Up policies described above and authorize the DeSoto County (MS) Alumnae Chapter of Delta Sigma Theta Sorority, Inc, to release my child to the persons listed above. I also agree to notify the DeSoto County (MS) Alumnae Chapter in writing of any changes to the above list of authorized persons.

Mother/Guardian Signature _____ Date: _____

Father/Guardian Signature _____ Date: _____

Delta Academy

CONTACT INFORMATION

Chapter President
DeSoto County (MS) Alumnae Chapter
E Darlene Williams
dcacpresident2@gmail.com

Chair, Educational Development
DeSoto County (MS) Alumnae Chapter
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