Austin Alumnae Chapter
Delta Sigma Theta Sorority, Inc.
Educational Development Youth Programs
Youth Participant Application

The Jeanne L. Noble **Delta Academy** was created out of an urgent sense that bold action was needed to save our young females (ages 11-14) from the perils of academic failure, low self-esteem, and crippled futures. The Austin Alumnae Chapter of Delta Sigma Theta Sorority, Inc. Delta Academy program is focused on building up self-esteem, self-confidence and an appreciation for the demand in an ever increasingly technological society through enrichment activities, interactive exposure to STEM related studies/careers, and service learning.

The **Delta GEMS** Program is a youth community service program of the Austin Alumnae Chapter of Delta Sigma Theta Sorority, Inc. The Delta GEMS Program (**D**eveloping **E**ffective **L**eadership **T**hrough **A**chieving, **G**rowing, and **E**mpowering **M**yself **S**uccessfully) targets teen girls, ages 14-18 (grades 9-12) and was created as an extension to the Dr. Betty Shabazz Delta Academy. The goal of the program is to develop strong, confident, and respectful young ladies and prepare them to take an active role in their success and society.

Please indicate (X) which program is the student interested in:

Delta Academy _____ Delta GEMS _____

All applications should be sent to:

Delta Sigma Theta Sorority, Inc.
c/o Educational Development
P.O. Box 301273
Austin, TX 78703

Applicant Information

Name _____ Birth Date _____ Age_____

Address_____ City _____State_____ Zip_____

Home Telephone _____ Mobile Telephone_____

Applicant's E-mail _____

School Information

School Name _____ Grade _____ GPA _____

School District _____

Student Employment

Are you currently employed? Yes☐ No☐

Company _____ Position/ Job Title _____

Telephone Number_____ Estimated Work Hours/ week _____

Do you work Saturdays? Yes☐ No☐

Extracurricular Activities

List all the extracurricular activities (including community, church activities, school, public service projects and interest) you are involved in. Be certain to include positions held and/or meeting days and times.

Is there anything that would prevent you from fully participating in the youth initiative activities? ☐ Yes ☐No

If yes, please indicate your conflicts:

In the past, have you participated in any of our mentor programs? (Check all that apply):

☐ Dr. Betty Shabazz Delta Academy ☐ Dr. Jeanne L. Noble Delta GEMS Institute

How did learn about the program?

☐ Church ☐ Friend ☐ Radio ☐ Flyer ☐ Current Member ☐ School

☐ Website ☐ Other _____

Parent Contact Information

Parents/Guardian _____

Address _____ (if different from above)

City _____State _____ Zip_____

Home Telephone _____ Work Telephone _____

Mobile Telephone _____ Parent E-mail _____

In the event of an emergency, please contact:

Name_____ Relationship to participant_____

Emergency Number_____ Alternate Contact Number_____

AUSTIN ALUMNAE CHAPTER
YOUTH INITIATIVES PARTICIPANT CONTRACT

As a member of the Austin Alumnae Chapter Youth Initiatives program, I agree to the following statements:

- **I will respect everyone's privacy**. There is to be no teasing or prying. Each individual has the right to decide whether to share private thoughts during Delta GEMS meetings or discussions. Anybody who wants to simply sit and listen may do so, with the understanding that participation is beneficial but voluntary
- **I will show everyone respect.** There will be no teasing or scolding. The idea is for the whole group to arrive at its goals, but each individual will progress at a different rate.
- **I will uphold everyone's confidentiality.** What happens and what is said within the group stays within the group. Group members should feel free to discuss their thoughts and feelings knowing they need not feel bashful or shy, or worry that friends or people outside the group will find out things they'd rather keep private.
- **I will trust my group members.** There will be no blaming and no lying. I promise to make my best effort to be honest, accepting that no one is perfect and everyone makes mistakes from time to time.
- **I will show up on time for group meetings and activities.**
- **I will complete all my homework assignments.**
- **I will listen to others without interrupting.**
- **I will be positive and try to encourage everyone in my group.**

If you agree to all of the above statements, please sign below:

_____
Applicant Name

_____
Date

DELTA SIGMA THETA SORORITY, INCORPORATED
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) 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.

(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/Guardian)

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

Austin Alumnae Chapter
Delta Sigma Theta Sorority, Inc.
Educational Development Youth Programs

Parent and Guardian Information/Forms

PARENTAL/GUARDIAN AFFIMATION

I, _____hereby give my permission to the Austin Alumnae 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: _____

PHOTOGRAPH, MEDIA AND VIDEO AUTHORIZATION RELEASE FORM

I/We,_____("Parent/Guardian"), as parent(s) or legal guardian(s) of_____,give permission for the Austin 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 mychild 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.

1/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

I/We authorize the persons listed below to pick-up my/our 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------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 Austin Alumnae Chapter to release my child to the persons listed above. I also agree to notify the Austin Alumnae Chapter in writing of any changes to the above list of authorized persons.

_____ _____

Parent/Guardian Signature Date

_____ _____

Parent/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: _____ Email 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_____ NO_____

Vision Problems: Glasses_____ Contacts_____

Hearing Problems: Hearing Aid _____

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

Participant Name (Last, First, M.I.):_____

Check one: ☐ Male ☐ Female

Date of Birth (mm/dd/yy): _____

Parent/Guardian Name: _____

Does Parent/Guardian live in the home with the child? ☐ Yes ☐No

Is/Has the child been under regular supervision of a physician? ☐ Yes ☐ No

Date of last physical examination: _____

Health and Development 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 the child have any significant health history, conditions, communicable illness, or restrictions that may affect child's participation in the youth initiative program? : ☐ Yes ☐No;

If yes, please provide detailed explanation_____

Does the child have any significant food/medication/environmental allergies that may require emergency medical care at the youth initiatives program? ☐ Yes ☐No;

If yes, please provide detailed explanation_____

Specify any other serious or severe illnesses or accidents: _____

Does the child take prescribed medications? Name the medications: _____

_____

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

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

Name the medications: _____

Frequency: _____

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 non-prescription medication may be available to your child:

_____For headaches/fever/muscle aches/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 AND 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_____

City/State/Zip Code_____

Home Phone_____ Work Phone_____

Cell Phone_____ E-mail Address_____

Name_____ Relationship_____

Home Phone_____ Work Phone_____

Cell Phone_____ E-mail Address_____

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 see 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