

**Delta Sigma Theta Sorority, Inc.
Greenville (SC) Alumnae Chapter**



**2017 – 2018
Delta Academy
and
Delta G.E.M.S.
Application Packet**



Delta Sigma Theta Sorority, Incorporated

Greenville (SC) Alumnae Chapter

Post Office Box 17704

Greenville, SC 29606

gvillescalumnae@hotmail.com

1-844-GSCADST

Overview of Programs

Program Name

Program Summary

Delta GEMS (Growing and Empowering Myself Successfully)

- Applicants must be young ladies in 9th – 12th grade (ages 14 – 18) in high school.
- The goals of Delta GEMS are to provide tools that enable girls to sharpen and enhance their skills to achieve high levels of academic success: to assist girls in proper goal setting, and decision-making, and planning for their futures – high school and beyond, and to create compassionate, caring, community –minded young women by actively involving them in service learning and community service opportunities.

You may send questions to: gvillescalumnae@hotmail.com

Dr. Betty Shabazz Delta Academy

- Applicants must be girls ages 11 – 14. If you are in this age range and are enrolled as a high school student, then Delta Academy would be the best program for you.
- The program 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 achieve in math, science, and technology, and be prepared to compete for the jobs of the future.
- You may send questions to: gvillescalumnae@hotmail.com



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Application Packet Requirements

(For Academy and GEMS Applicants)

- Signed application (parent / guardian signature required if applicant is under 18)
- Signed program forms (parent / guardian signature required if applicant is under 18)
- One (1) letter of recommendation from any of the following persons:
(If you participated in Academy or GEMS during the most recent school year, you are not required to submit a letter of recommendation.)
 - Teacher / Professor
 - Organization Sponsor / Advisor
 - Community Leader
 - Church leader
 - Volunteer Coordinator /Employer
 - Academic Counselor/ Advisor

The letter should include the following and must be on letterhead: (1) the length of time they have known the applicant (2) applicant's personal qualities, character, leadership abilities, and/or any special attributes; and (3) why they believe the applicant has the perseverance to succeed in our program.

ALL items must be submitted together for the application packet to be considered complete.

Packets must be postmarked by **October 13, 2017** to be considered for the Academy and GEMS programs.

Mail all information to:

Greenville (SC) Alumnae Chapter
Delta Sigma Theta Sorority, Incorporated
Attention: Youth Programs
Post Office Box 17704
Greenville, SC 29606

Selection and Notification

Applicants accepted into the program will receive notification by email or phone with details and the program schedule. **Sessions are on the 3rd Tuesday of the month and will begin on November 20, 2017** (with possible date and time changes when necessary). Please note all program forms will be required and completed in entirety upon acceptance into any of the GSCAC youth programs. The Delta Academy kickoff is **Thursday, October 26, 2017 from 6:15 pm – 7:15 pm.**



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Application Form
All application packets must be postmarked by September 25, 2017.
I. Applicant Information

Program you are applying for (please check or circle one)	GSCAC Delta GEMS	GSCAC Delta Academy
I am a returning participant (please check or circle one)	YES	NO
First Name	Middle Name	Last Name
Street Address		
City	State	Zip
Home Phone	Cell Phone	Date of Birth (Month/Day/Year)
Email Address		
School Currently Attending		City State
Grade Level	Guidance Counselor Name	Most recent cumulative GPA

II. Parent / Guardian Information

Name of Mother/Guardian			
Address (if different from applicant's)	City	State	Zip
Cell Phone	Home Phone	Work Phone	
Email Address			
Name of Father/Guardian			
Address (if different from applicant's)	City	State	Zip
Cell Phone	Home Phone	Work Phone	
Email Address			

III. Honors and Awards (e.g., academic, athletic, community, and/or school awards)

IV. Church and Community Related Activities

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CONFIDENTIALITY POLICY

It is the policy of Greenville (SC) Alumnae Chapter of Delta Sigma Theta Sorority, Incorporated (“DST”) to protect the confidentiality of its youth participants and their families. Except as provided below, Chapter will only share information about participants and their families with other Delta chapter members and Delta employees assigned to assist with youth initiative programs, on a “need to know basis.”

To carry out the mission of its youth programs (**Delta Academy and Delta GEMS**) and to better serve the needs of the youth participants, the Greenville (SC) Alumnae Chapter must collect certain personal information about youth participants and their families, including, but not limited to, the following “Confidential Information”:

- Name, address, and age of participant
- School participant attends
- Names and addresses of parents or guardian.
- Medications and physical conditions/limitations
- Any distinguishing marks or characteristics (such as disfigurement or physical limitations)

Limits of Confidentiality: Confidential information may be shared with individuals or organizations as specified below under the following conditions, and *provided that* the party to who seeks any disclosure agrees in writing to maintain the confidentiality of the disclosed information as specified in this Confidentiality Policy:

- Delta Officers and Members of the Board have access to any participant’s files only upon directive by the National President. Any directive shall identify the person(s) authorized to review such records; the specific purpose for such review; and the period of time during which access shall be granted. Such Officers or Members of the Board granted access shall be required to comply with this Confidentiality Policy and may use the information only for purposes specified in the National President’s directive.
- Information may only be provided to law enforcement officials or the courts pursuant to a valid and enforceable subpoena or court order.
- Information may be provided to Delta’s legal counsel in the event of litigation or potential litigation involving Delta and/or the Program participants or any aspect of the Program.
- Members of Chapter and volunteers who observe or suspect child abuse are “mandatory reporters” and, as such, must disclose suspected abuse to the proper authorities, and in making such reports, may disclose “Confidential Information.”

Safekeeping of Confidential Records: The President of the Greenville (SC) Alumnae Chapter or her designee shall be the custodian of confidential records. It is her responsibility to supervise the management of Confidential Information in order to ensure safekeeping, accuracy, accountability, and compliance with this Confidentiality Policy.

Requests for Confidential Information by Other Agencies: Any request from other organizations or persons for Confidential Information shall be honored only if the request is accompanied by written authorization from the parents or guardians of the youth participant expressly permitting the release of the requested information.

Violations of Confidentiality: Known violations of this Confidentiality Policy (by volunteers or youth participants) shall be reported to the chapter president or her designee. A violation of this Confidentiality Policy shall result in disciplinary action up to and including suspension or termination from the Program, as appropriate.

No Liability. There shall be no liability to Delta Sigma Theta Sorority, Incorporated, the Greenville (SC) Alumnae Chapter, or any volunteer or youth participant for disclosing information that is required to be disclosed by a court, an administrative body of competent jurisdiction, a governmental agency, or by operation of law.



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PARENTAL/GUARDIAN AFFIRMATION

I, _____, hereby give my permission to the Greenville (SC) Alumnae Chapter of Delta Sigma Theta Sorority, Incorporated for _____ to participate in the **(circle one) Delta Academy / Delta GEMS** 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 my child’s participation in the **(circle one) Delta Academy / Delta GEMS** 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: _____



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YOUTH SIGN IN / SIGN OUT POLICY

It is the policy of the **Greenville (SC) Alumnae Chapter of Delta Sigma Theta Sorority, Inc.** (GSCAC), that all participants (youth, members, and other volunteers) and visitors must sign-in and out of GSCAC's Youth Program ("Program"). The required sign in/sign out procedures are as follows:

1. The chapter shall maintain and use a sign in log that reflects the following: name of the youth initiative; the date; the time in and the time out; and the names of the participants, with a column for the participant and visitors to check her/their status (as member, youth, volunteer, or visitor). The form should distinguish whether a member is assisting with the Program or is a visitor or observer.
2. Only authorized persons (those identified in writing) will be allowed to pick up a participant from the Program. Volunteers shall refuse to release a participant to any person, whether related or unrelated to the youth, who has not been authorized, in writing, by the parent or guardian to receive the youth.
3. One of the following procedures shall be observed during departure and return:
 - a. Parents or an authorized representative will sign out youth.
 - b. Older youth who have written parental permission will be allowed to leave the program on their own. Members will establish a system where the youth check themselves out with an approved volunteer; the approved volunteer will ensure that the youth signed out and initialed the attendance sheet.
 - c. When Chapters provide transportation to off-site sponsored events, members will develop and implement a system to ensure that all youth participating for the day board the correct bus or other vehicle at the time of departure to and return from a scheduled activity.
4. **Failure to pick up your child at the conclusion of a session or activity will result in contact being made with the local police department and/or child protective services.**
5. If a parent or guardian wishes to arrange alternative transportation for their child to attend an offsite activity, the youth may join the group at the event or activity, but the **Greenville (SC) Alumnae Chapter of Delta Sigma Theta Sorority, Inc.** assumes no responsibility or liability for the youth participant for any non-chapter-sponsored activity or transportation.



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EMERGENCY CONTACT INFORMATION

Parent/Guardian #1

Name Relationship: _____

Street Address: _____ City _____ State/Zip: _____

Contact Phone Number: _____ E-mail address: _____

Parent/Guardian #2

Name Relationship: _____

Street Address: _____ City _____ State/Zip: _____

Contact Phone Number: _____ 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: _____

Contact Phone Number: _____ Alternate Number: _____

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: _____

PHYSICIAN & INSURANCE INFORMATION

Name of Child's Physician: _____ Phone: _____

Health Insurance Company: _____ Phone: _____

Name of Policy Holder: _____

Policy Number Group Number: _____

Name of Policy Holder's Employer: _____



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PHOTOGRAPH, MEDIA AND VIDEO AUTHORIZATION RELEASE FORM

I/We, (“Parent/Guardian”), as parent(s) or legal guardian(s) of _____, give permission for the Greenville (SC) 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 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 (circle one) Delta Academy / Delta GEMS 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



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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



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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: _____

Print Name: _____ Date: _____

(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: _____

Print Name: _____ 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 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: _____



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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 Greenville (SC) Alumnae 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



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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) Yes or No ADD/ADHD: Yes or No

Other Health Issues: _____

Allergies/Sensitivities (be specific): _____

Food Allergies: _____

Required Medications: _____

Bee sting or insect bite Allergies: _____

Other Allergic Reactions: _____

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



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Health History:

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

Gender (circle one): Male or Female DOB (mm/dd/yy): _____

Parent/Guardian Name: _____

Parent/Guardian live in home with child? Yes or No

Parent/Guardian Name: _____

Parent/Guardian live at home with child? Yes or No

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

Name, address, and phone number of attending physician

Date of last physical exam: _____

Health and Developmental History:

Childhood illnesses: Circle any and all that may 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 GSCAC youth initiatives program?

(Circle one) Yes or No

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?

(Circle one) Yes or No

If yes, please provide detailed explanation: _____



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Specify any other serious or severe illnesses or accidents: _____

Does child take prescribed medications? Yes or No

Name the medications: _____

Frequency Taken: _____

(For any medications or treatment required during the course of the GSCAC 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 or 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

Print Name



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PHYSICIAN & INSURANCE INFORMATION

Name of Child's Physician: _____ Phone: _____

Health Insurance Company: _____ Policy /Group Number: _____

Name of Policy Holder: _____

Name of Policy Holder's Employer: _____

EMERGENCY CONTACT INFORMATION

Parent/Guardian #1

Name: _____ Relationship: _____

Street Address _____ City _____ State / Zip Code _____

Contact / Cell Phone: _____ E-mail address: _____

Parent/Guardian #2

Name: _____ Relationship: _____

Street Address _____ City _____ State / Zip Code _____

Contact / 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: _____

Contact / Cell Phone: _____ E-mail address: _____

Name: _____ Relationship to student: _____

Contact / 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 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	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 GSCAC 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 GSCAC 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

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 **Delta Academy, Delta GEMS** youth initiatives program. Medications should be brought to the youth initiatives program by the parent or responsible adult and taken to **GSCAC Coordinator** of the youth program. 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.

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.