



▲ Delta Sigma Theta Sorority, Inc.- Compton Alumnae Chapter ▲ P.O. Box 5348, Compton, CA 90220 ▲

Web:<http://cadst.org/>

DELTA ACADEMY /GEMS / EMBODI APPLICATION

This Application is for (please check one box):

DELTA ACADEMY
(Girls Elementary & Middle School)

GEMS
(Girls: High School)

EMBODI
(Boys: Elementary, Middle, & High School)

YOUTH NAME _____

YOUTH NICK NAME (IF ANY) _____ AGE: _____

SCHOOL _____

GRADE _____ BIRTHDATE ____/____/____ T-SHIRT SIZE _____

YOUTH EMAIL: _____

PARENT/GUARDIAN NAME _____

HOME ADDRESS _____
STREET ADDRESS APT. NO. CITY ZIP CODE

PHONE # (HOME) _____

RELATIONSHIP TO STUDENT: _____

PARENT/GUARDIAN PHONE #s:
(WORK) _____ (CELL) _____

PARENT/GUARDIAN EMAIL: _____

STUDENTS AND PARENTS/GUARDIANS PLEASE PRINT AND SIGN BELOW:

STUDENT NAME (PRINT) SIGNATURE PARENT/GUARDIAN NAME (PRINT) SIGNATURE

PLEASE RETURN THIS APPLICATION OR BRING TO ORIENTATION SEPTEMBER 15th, 2018:

Delta Sigma Theta Sorority Inc.
Compton Alumnae Chapter
Attn: Youth Programs
PO BOX 5348
Compton, CA 90224

Delta Sigma Theta Sorority, Inc – Compton Alumnae Chapter
Youth Programs – Delta Academy / GEMS / EMBODI
Student Information Sheet

COMPLETE THE FOLLOWING SENTENCES:

I AM _____, _____, AND
_____.

I LIKE TO _____.

MY FAVORITE _____ IS _____.

MY FAVORITE SCHOOL SUBJECT IS _____

MY LEAST FAVORITE SUBJECT IS _____

I AM GOOD AT _____

I GET ALONG WITH PEOPLE WHO ARE _____.

WHAT ARE YOUR TOP 3 FUTURE GOALS?

1. _____
2. _____
3. _____

LIST ANY ACTIVITIES THAT YOU ARE CURRENTLY INVOLVED IN (FOR EXAMPLE-
CLUBS, DRILL TEAM, CHOIR, SPORTS, ETC.).

WHY ARE YOU INTERESTED IN THE YOUTH PROGRAM?

LIST 3 THINGS YOU WOULD LIKE TO LEARN OR TALK ABOUT.

1. _____
2. _____
3. _____

**Delta Sigma Theta Sorority, Inc – Compton Alumnae Chapter
Youth Programs – Delta Academy / GEMS / EMBODI**

Youth Program Participant Photo Release Form Video & Photo Display

Delta Sigma Theta Sorority Inc.; Compton Alumnae Chapter and Compton Unified School District may take many pictures of the children throughout the year to illustrate, for you and them, the many activities in which they are engaged. Some photos will be used on the Chapter Web Site, regional and National Web and Published articles, Local and National Newspapers and magazines and as well as possible research papers, general books and publications made by the volunteers and children or displayed in the Delta Sigma Theta Sorority Inc.; Compton Alumnae Chapter and Compton Unified School District functions and rooms.

Videotapes are also made of programs and projects activities and may be posted on the Delta Sigma Theta Sorority Inc Chapter, Regional and National Websites as well along as the Compton Unified School Web Site.

I grant permission to the Delta Sigma Theta Sorority Inc.; Compton Alumnae Chapter and Compton Unified School District to electronically record my child's image during these programs and projects activities, which may appear in the forms described above.

Youth/ Child's Name: _____

Parent/ Guardian Name: _____

Parent/ Guardian Parent's
Signature _____

I certify that I am a custodial parent and have the aforementioned rights to assign.

Signature of
Parent or Guardian: _____

Address: _____

Date: _____

**Delta Sigma Theta Sorority, Inc – Compton Alumnae Chapter
Youth Programs – Delta Academy / GEMS / EMBODI**

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)¹ 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

¹set 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.

**Delta Sigma Theta Sorority, Inc – Compton Alumnae Chapter
Youth Programs – Delta Academy / GEMS / EMBODI**

Youth Code of Conduct Acknowledgement Form

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*.

Print Name - Youth

Signature - Youth

Date _____

I have read and understand the *Code of Conduct* and sanctions for violating the *Code of Conduct*. I understand that my child's compliance with the *Code of Conduct* is a condition of her/his participation in the **Delta Sigma Theta Sorority, Inc - Compton Alumnae Chapter's Youth Programs – Delta Academy / GEMS / EMBODI**. I agree that the sanctions for violating the *Code of Conduct* are reasonable and will help my child comply.

Print Name – Parent/Guardian

Signature – Parent/Guardian

Date _____

**Delta Sigma Theta Sorority, Inc – Compton Alumnae Chapter
Youth Programs – Delta Academy / GEMS / EMBODI**

Youth Authorization Pickup Form

I authorize the persons listed below to pickup my child from the Delta Sigma Theta Sorority, Inc – Compton Alumnae Chapter 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 _____

**Delta Sigma Theta Sorority, Inc – Compton Alumnae Chapter
Youth Programs – Delta Academy / GEMS / EMBODI**

EMERGENCY MEDICAL TREATMENT AUTHORIZATION

Name of Minor: _____

Date of Birth _____ Age _____

Address: _____

City/State/Zip Code _____

Parent/Guardian Home Phone _____

Parent Cell Phone _____ Parent E-mail _____

Youth'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

Glasses

Inhaler required at Program

Hearing Problems / Hearing Aid

Vision Problems

Contacts

ADD/ADHD

Other:

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

**Delta Sigma Theta Sorority, Inc – Compton Alumnae Chapter
Youth Programs – Delta Academy / GEMS / EMBODI**

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 | 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 (list all foods): _____

**Delta Sigma Theta Sorority, Inc – Compton Alumnae Chapter
Youth Programs – Delta Academy / GEMS / EMBODI**

Health History (page 2):

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 _____

**Delta Sigma Theta Sorority, Inc – Compton Alumnae Chapter
Youth Programs – Delta Academy / GEMS / EMBODI**

Physician & Health 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 _____

**Delta Sigma Theta Sorority, Inc – Compton Alumnae Chapter
Youth Programs – Delta Academy / GEMS / EMBODI**

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: _____

**Delta Sigma Theta Sorority, Inc – Compton Alumnae Chapter
Youth Programs – Delta Academy / GEMS / EMBODI**

Parental Permission Form Administration of Prescription Medication

I/We hereby give permission for _____ to take _____
at the **Delta Sigma Theta Sorority, Inc – Compton Alumnae Chapter** 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 _____

**Delta Sigma Theta Sorority, Inc – Compton Alumnae Chapter
Youth Programs – Delta Academy / GEMS / EMBODI**

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 Compton Alumnae Chapter 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 Sigma Theta Sorority, Inc, Compton Alumnae Chapter youth initiatives program. Medications should be brought to the Delta Sigma Theta Sorority, Inc, Compton Alumnae Chapter 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.¹
2. A record will be maintained every time a medication is given. The record includes the student's name, date, time of administration, and dosage.

**Delta Sigma Theta Sorority, Inc – Compton Alumnae Chapter
Youth Programs – Delta Academy / GEMS / EMBODI**

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 _____

**Delta Sigma Theta Sorority, Inc – Compton Alumnae Chapter
Youth Programs – Delta Academy / GEMS / EMBODI**

Youth Program Participant Form

Special Topic
PERMISSION SLIP

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. I/we understand that these activities will be provided for my/our Child by the **Compton Alumnae Chapter – Delta Sigma Theta Sorority, Inc.** The Specific Special Topic- **TO BE ANNOUNCED (TBA)** scheduled for **April 20th, 2019.** The discussion will be very graphic and mature level discussions.

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 this activity, 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.

_____ YES –My child can listen and /or participate in a workshop and discussion on TOPIC: TBA

_____ NO –My child can NOT listen and/ or participate in a workshop and discussion on TOPIC: TBA

Parent/Guardian Signature
Emergency Phone- _____
Emergency Email _____

Date

Parent/Guardian Signature
Emergency Phone _____
Emergency Email _____

Date

Delta Sigma Theta Sorority Inc.
Compton Alumnae Chapter

(Fill Out by All Program Participants)
DELTA ACADEM, GEMS , EMBODI and/or Other Program
*****All Participants Must Sign*****

Waiver & Liability Form

In consideration of being permitted to utilize the facilities, services and programs of the Delta Sigma Theta Sorority Inc., Compton Alumnae Chapter and Compton Unified School District (or my children to so participate) for any purpose, including, but not limited to observation or use of facilities or equipment or participation in any offsite program affiliated with the Delta Sigma Theta Sorority Inc., Compton Alumnae Chapter and Compton Unified School District, the undersigned for himself or herself and such participating children and any personal representatives, heirs, and next of kin, hereby acknowledges, agrees and represents that he or she has or immediately upon entering or participating will inspect and carefully consider such premises and facilities or the affiliated program. It is further warranted that participation in such affiliated program constitutes an acknowledgment that such premises and all facilities and equipment thereof and such affiliated programs have been inspected and carefully considered and that the undersigned finds and accepts same as being safe and reasonably suited for the purpose of such observation, use or participation by the undersigned and such children.

IN FURTHER CONSIDERATION OF BEING PERMITTED TO ENTER THE DELTA SIGMA THETA SORORITY INC., COMPTON ALUMNAE CHAPTER AND COMPTON UNIFIED SCHOOL DISTRICT FOR ANY PURPOSE INCLUDING BUT NOT LIMITED TO OBSERVATION, USE OF FACILITIES OR EQUIPMENT, OR PARTICIPATION IN ANY OFFSITE PROGRAM AFFILIATED WITH THE DELTA SIGMA THETA SORORITY INC., COMPTON ALUMNAE CHAPTER, THE UNDERSIGNED HEREBY AGREES TO THE FOLLOWING:

1. THE UNDERSIGNED on his or her behalf and behalf of such children, to the extent permitted by law, HEREBY RELEASES, WAIVES, DISCHARGES, AND COVENANTS NOT TO SUE the Delta Sigma Theta Sorority Inc., Compton Alumnae Chapter and Compton Unified School District, its directors, officers, employees, and agents (hereinafter referred to as the 'releases') from all liability to the undersigned or such children and all his personal representatives, assigns, heirs, and next of kin for any loss or damage, and any claim or demands therefore on account of injury to the person or property or resulting in death of the undersigned or such children whether caused by the negligence of the releases or otherwise, while the undersigned or such children is in, upon, or about the premises or any facilities or equipment therein or participating in any program affiliated with the Delta Sigma Theta Sorority Inc., Compton Alumnae Chapter and Compton Unified School District .
2. THE UNDERSIGNED, to the extent permitted by law, HEREBY AGREES TO INDEMNIFY AND SAVE AND HOLD HARMLESS the releases and each of them from any loss, liability, damage or cost they may incur due to the presence of the undersigned or such children in, upon or about the Delta Sigma Theta Sorority Inc., Compton Alumnae Chapter and Compton Unified School District premises or in any way observing or using any facilities or equipment of the Delta Sigma Theta Sorority Inc., Compton Alumnae Chapter and Compton Unified School District or participating in any program affiliated with the Delta Sigma Theta Sorority Inc., Compton Alumnae Chapter and Compton Unified School District whether caused by negligence of the release or otherwise.
3. THE UNDERSIGNED, to the extent permitted by law, HEREBY ASSUMES FULL RESPONSIBILITY FOR ANY RISK OF BODILY INJURY, DEATH OR PROPERTY DAMAGE to the undersigned or such children due to the negligence of releases or otherwise while using the premises or any facilities or equipment thereon or participating in any program affiliated with the Delta Sigma Theta Sorority Inc., Compton Alumnae Chapter and Compton Unified School District.

THE UNDERSIGNED further expressly agrees that the foregoing RELEASE, WAIVER AND INDEMNITY AGREEMENT is intended to be as broad and inclusive as is permitted by the law of the State of California and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

The UNDERSIGNED HAS READ AND VOLUNTARILY SIGNS THE RELEASE AND WAIVER OF LIABILITY AND INDEMNITY AGREEMENT and further agrees that no oral representations, statements or inducement apart from the foregoing written agreement have been made.

Sign Name(s) Here: _____ Date: _____
Name Print: _____

(For minors under 18 years, signature of all parents and guardians is required.)
Parent Sign Name(s) Here: _____ Date: _____
Name Print: _____