Chicago Alumnae Chapter
Delta Sigma Theta Sorority, Inc.

2017-18 DELTA ACADEMY PROGRAM APPLICATION

Chapter President Deborah Douglas

Delta Academy Program Chairs
Julia Hill, Wendy Winston
Dear Parent/Guardian:

The Chicago Alumnae Chapter of Delta Sigma Theta Sorority, Inc. invites your daughter to participate in its Dr. Betty Shabazz Delta Academy which is one of the Sorority’s national initiatives for youth. The Delta Academy is named for the outstanding and accomplished widow of Malcolm X, in recognition of her contributions as an outstanding educator and role model for young women.

The symbol for the Delta Academy is the Dream Catcher. A Dream Catcher, from Native American culture, is believed to possess the power to capture bad dreams, entangling them in the Catcher’s web, thus allowing only good dreams to pass through and into the person’s being. The Delta Academy is a dream catcher! It helps its members recognize, receive and plan for reaching their dreams and goals, as well as making their dreams a part of their being and a foundation for their future. The goals of the Delta Academy are achieved through challenging and fun activities, field trips, and other special incentives. A particular emphasis is placed on African American history, literacy, self-esteem, non-traditional careers, service learning, and leadership development.

The “Delta Academy” specially designed for young ladies 11 – 14 years of age, will provide scholarship, service learning activities, and sisterhood enrichment opportunities for young ladies to prepare them for the 21st century and beyond. The “Delta Academy” is seeking young ladies who are: interested in developing their leadership skills, interested in learning new things and who want to do all of these things in a fun environment.

If you would like for your daughter to become a part of this rewarding and exciting experience, please complete the attached application package, including the student application, parent consent form and health history form. The packet must be received no than 11:59PM CST on Saturday, October 7, 2017. There are a limited number of slots so you are encouraged to return your application, via email, as soon as possible.

All applications are to be sent to Delta Sigma Theta Sorority, Inc., Chicago Alumnae Chapter c/o Delta Academy Program P.O. Box 8235 Chicago, Illinois 60680 or via email. Committee email address: academy.chideltas@gmail.com

If you have questions, please feel free to contact Committee Chairs, Julia Hill at 773/569-0868 or Wendy Winston at 773/677-9433.

Sincerely,

[Signature]

Deborah M. Douglas, President
Chicago Alumnae Chapter
Delta Sigma Theta Sorority, Inc.
president.chideltas@gmail.com
(773) 994-2422
Chicago Alumnae Chapter

2017-18 Delta Academy Photo/Video Release Form

I/We, _________________________________ (“Parent/Guardian”), as parent(s) or legal guardian(s) of ________________________________, give permission for Chicago 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 Dr. Betty Shabazz Delta Academy Youth Initiative Program on __________________________(date of the event), 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 Dr. Betty Shabazz 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, 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 ________________________________, and do hereby give my/our consent without reservation to the foregoing on behalf of my/our child.

________________________________________  __________________________
Signature of Parent/Guardian                                      Date
__________________________________________                       ________________

Signature of Parent/Guardian                                      Date
__________________________________________                       ________________

Chicago Alumnae Chapter

2017-18 DELTA ACADEMY PARENTAL AFFIRMATION

I, ________________________________, Parent/Guardian, under penalty of perjury, do hereby affirm to the Chicago Alumnae Chapter of Delta Sigma Theta Sorority, Incorporated that I authorize the participation of ________________________________, Participant Minor Child, in the Dr. Betty Shabazz 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: ________________________________

2017-18 DELTA ACADEMY 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”), 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 Dr. Betty Shabazz 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 Release.

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: __________________________________________________________________________________

2017-18 DELTA ACADEMY CODE OF CONDUCT FOR YOUTH PARTICIPATING IN YOUTH INITIATIVES PROGRAM

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-day suspension from program
4th 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*
2nd Time: 1-day suspension from program
3rd Time: 1-week suspension from program
*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.

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*.

<table>
<thead>
<tr>
<th>Youth’s Printed Name</th>
<th>Youth’s Signature</th>
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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 participation in the Dr. Betty Shabazz Delta Academy program. I agree that the sanctions for violating the *Code of Conduct* are reasonable and will help my child comply.

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<tr>
<th>Parent/Guardian’s Printed Name</th>
<th>Parent/Guardian’s Signature</th>
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Date_____________________

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**Chicago Alumnae Chapter**

### 2017-18 DELTA ACADEMY YOUTH PICK-UP AUTHORIZATION FORM

I authorize the persons listed below to pick-up my child from the Dr. Betty Shabazz Delta Academy 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 __________________________
By signing below, I verify that I have read and agree to the Student Pick-Up policies described above and authorize the Chicago Alumnae Chapter to release my child to the persons listed above. I also agree to notify the Chicago Alumnae Chapter in writing of any changes to the above list of authorized persons.

Parent/Guardian Signature ___________________________________ Date ____________

9/2017-6/2018

Chicago Alumnae Chapter

2017-18 DELTA ACADEMY FIELD TRIP PERMISSION

I/We, _________________________________ (“Parent/Guardian”), as parent(s) or legal guardian(s) of _______________________________ (“Child”), give permission for my/our Child to participate in the Dr. Betty Shabazz Delta Academy 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
2017-18 DELTA ACADEMY MEDICAL INFORMATION FORM

Today's Date: ________________

**Health History:**

Child’s Name ____________________________

Gender (check one): Male_____ Female_____ DOB (mm/dd/yy): __________________________

Parent/Guardian Name: ____________________________

Does this parent/guardian live in home with child? __________________________

Parent/Guardian Name: ____________________________

Does this parent/guardian live at home with child? __________________________

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

Name and address of physician ____________________________

Date of last physical exam: __________________________

**2017-18 Delta Academy Health and Developmental 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 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 __________________________
2017-18 Delta Academy Health and Developmental History (cont.):

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? ________________
Name the medications: _______________________________________________
Frequency Taken: ______________________________________________________

Does child have any allergies? ________________________________
Specify: _____________________________________________________________

Does the student use any special device(s) (i.e. hearing aids, cochlear implants, etc.): _______?
Name the Device(s): _________________________________________________
Reason for use: _______________________________________________________
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 _______________

2017-18 DELTA ACADEMY 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 _ Inhaler required at Program
_ Vision Problems _ Glasses _ Contacts
_ Hearing Problems _ Hearing Aid(s)
_ ADD/ADHD
Other

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

______________________________

2017-18 DELTA ACADEMY 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), Naproksen (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., Cepacol 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 __________

2017-18 DELTA ACADEMY 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 ________________________________________________
Chicago Alumnae Chapter

2017-18 DELTA ACADEMY 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 _____________________________________________
Physician’s telephone number _____________________________

2017-18 DELTA ACADEMY PARENTAL PERMISSION FORM
ADMINISTRATION OF PRESCRIPTION MEDICATION

I/We hereby give permission for ______________________________ to take ______________________________ at the Dr. Betty Shabazz Delta Academy youth initiatives program as ordered by his/her physician identified above. I/We understand that it is my/our child’s responsibility to report an authorized medical professional of the program 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 (“Delta”), its officers, National Executive Board, employees, members, local chapters, representatives, agents, affiliates, assigns, the Dr. Betty Shabazz 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 the drug. The Dr. Betty Shabazz Delta Academy youth initiatives program reserves the right to refrain from administering medication if in the judgment of the Dr. Betty Shabazz Delta Academy 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 Dr. Betty Shabazz Delta Academy youth initiatives program by me/us in the original appropriately labeled container. If I/we cannot bring the medication to the Dr. Betty Shabazz Delta Academy youth initiatives program, I/we will call the Dr. Betty Shabazz Delta Academy 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 ____________________
2017-18 DELTA ACADEMY 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, the Dr. Betty Shabazz 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 Dr. Betty Shabazz Delta Academy youth initiatives program. Medications should be brought to the Dr. Betty Shabazz Delta Academy youth initiatives program by the parent or responsible adult and taken to an authorized medical professional of the 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 Dr. Betty Shabazz 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 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.

The failure to disclose any type of medications or medical condition will release the Chicago Alumnae Chapter of Delta Sigma Theta, members and volunteers of liability.