Columbia (MD) Alumnae Chapter
Delta Sigma Theta Sorority, Inc.

August 22, 2013

Dear Prospective Betty Shabazz Delta Academy Participant,

I am pleased to announce our 17th year of the Columbia (MD) Alumnae Chapter of Delta Sigma Theta Sorority Incorporated's Dr. Betty Shabazz Delta Academy. I want to personally thank you for your participation last year which helped make our program a huge success! The purpose of this letter is to extend a special invitation for you to return again this year and bring a friend!

We have some new and exciting activities planned for our participants this year as well as some fun-filled field trips. **All interested participants are asked to attend the Information Session on September 28 2012 from 10:00am-11:30am at the Johns Hopkins Applied Physics Laboratory.** Enclosed is a 2013-2014 Participant Application for you to complete and return. Feel free to make copies for all of your friends that may be interested in participating this year. As an incentive, we are giving away a prize to the young lady who brings the most new participants to the program.

As always, I am looking forward to a great program year. If you have any questions regarding the program, please contact Khadijah Supreme at (443) 745-2017 or drbettyshabazzacademy@colmddst.org.

Sincerely,

Melinda Pope

Melinda Pope
Chapter President
Columbia (MD) Alumnae Chapter
Delta Sigma Theta Sorority, Inc.

PO Box 2395 Columbia, MD 21045 (410) 730-9553
chapterpresident@colmddst.org colmddst.org

Columbia (MD) Alumnae Chapter
Delta Sigma Theta Sorority, Inc.
Dr. Betty Shabazz Delta Academy

Attachment 1

PROGRAM DESCRIPTION

The Columbia (MD) Alumnae Chapter of Delta Sigma Theta Sorority, Inc. is proud to announce our 16th year of the Dr. Betty Shabazz Delta Academy. The Academy is designed to encourage African-American girls between the ages of 11 and 14 to pursue careers in math, science, and technology. The Academy also promotes development in leadership, community service, and the social graces. The Academy usually meets on the fourth Saturday of the month; however, some months have multiple activities planned. All interested participants and parents are asked to attend an Information Session on September 28, 2013, from 10:00 AM to 11:30 AM at the Johns Hopkins Applied Physics Laboratory in Laurel, Maryland.

A variety of work sessions and field trips have been planned for the coming year, and your involvement is vital to the success of our program. Therefore, you may be asked to actively participate in certain activities with your daughter. If you have any questions regarding the program or to request an application, please email us at drbettyshabazzacademy@colmddst.org.

Participant Application Criteria

In order to participate in the Dr. Betty Shabazz Delta Academy, specific criteria and guidelines must be met by applicants as described below.

- Attend a Howard County Public School.
- All participants must be African-American girls. This is a gender-specific program.
- Girls must be no younger than 11 years old and no older than 14 years old as of their most recent birthday.
- Each girl must complete and submit a Participant Application Form (attached).

Participant Profile

The Delta Academy is designed for girls who exemplify one or more of the following characteristics:

- Interested in developing their leadership skills
- Interested in video games, computers, and technology
- Enjoy learning new things
- Expressed an interest in math, science, and technology and/or careers that are considered nontraditional

COMPLETED APPLICATIONS MAY EITHER BE BROUGHT WITH THE PARTICIPANT TO THE INFORMATION SESSION ON SATURDAY, SEPTEMBER 28, 2013, OR MAILED WITH A POSTMARK ON OR BEFORE TUESDAY, SEPTEMBER 23, 2013, TO:

Columbia (MD) Alumnae Chapter
Delta Sigma Theta Sorority, Inc.
Attn: Betty Shabazz
P.O. Box 2395
Columbia, Maryland 21045

Columbia (MD) Alumnae Chapter
Delta Sigma Theta Sorority, Inc.
Dr. Betty Shabazz Delta Academy

Attachment 1

PARTICIPANT APPLICATION

Participant's Information:

Name: _____ Date of Birth:_____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

School: _____ Grade: _____

Participant's E-mail: _____

T-Shirt Size (circle one): Adult-S Adult-M Adult-L Adult-XL Adult-2XL

Have you participated in the Dr. Betty Shabazz Delta Academy Program before? ___Yes ___No

If yes, please state when: _____

Please list extra-curricular activities in which you participate (indicate offices held, if applicable). You may attach a sheet to the application if more room is needed.

_____

_____

_____

Is there anything that you consider special or unique about yourself that you would like to share? Please explain.

_____

_____

_____

Parent(s)/Guardian(s) Information:

Name(s): _____

Home Phone: __(_____)_____ Alternate Phone: __(_____)_____

Parent's E-mail Address: _____

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Attachment 1

PARTICIPANT APPLICATION (CONT.)

Please write an essay below answering the following question: What benefits do you hope to gain from participating in a program that targets mathematics, science, and technology?

On a scale of 1 to 10 (10 being the highest) rate your interest in mathematics, science, and technology.

Mathematics Interests	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
Science Interests	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
Technology Interests	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

COMPLETED APPLICATIONS MAY EITHER BE BROUGHT WITH THE PARTICIPANT TO THE INFORMATION SESSION ON SATURDAY, SEPTEMBER 28, 2013, OR MAILED WITH A POSTMARK ON OR BEFORE TUESDAY, SEPTEMBER 23, 2013, TO:

Columbia (MD) Alumnae Chapter
Delta Sigma Theta Sorority, Inc.
ATTN: Betty Shabazz
P.O. Box 2395
Columbia, Maryland 21045

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Dr. Betty Shabazz Delta Academy

Attachment 2

PARENTAL AFFIRMATION

I, _____, Parent/Guardian, under penalty of perjury, do hereby affirm to the *Columbia (MD) 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:_____

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 "Releasees"), 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 Releasees, unless such injury, illness, death, property damage or loss is a direct result of the willful misconduct of any Releasee.

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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Attachment 2

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.

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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*.

Print Name:_____

Signature:_____

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.

Print Name:_____

Signature:_____

Date:_____

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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:_____

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MEDICAL INFORMATION FORM

Today's Date:_____

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 in home with child? _____

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

Child's Physician's Name: _____

Physician's Address: _____

Date of child's last physical exam: _____

HEALTH AND DEVELOPMENTAL HISTORY:

Childhood Illness:

Circle 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 *Dr. Betty Shabazz Delta Academy* youth initiatives program?
Check one: Yes_____ No_____

If yes, please provide detailed explanation:_____
_____

Does child have any significant food/medication/environmental allergies that may require emergency medical care at the *Dr. Betty Shabazz Delta Academy* youth initiatives program?
Check one: Yes_____ 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? Check one: Yes_____ No_____
If yes, list the medications:_____

_____

Frequency Taken:_____
(For any medications or treatment required during the course of the *Dr. Betty Shabazz Delta Academy* youth initiatives program, a Medication Authorization Form should be completed and submitted with this form.)

Does child take any over the counter medications frequently? Check one: Yes_____ No_____
If yes, list the medications:_____

_____

Does child have any allergies? Check one: Yes_____ No_____
If yes, specify:_____

_____

Does the student use any special device(s) (i.e. hearing aids, cochlear implants, etc.)?
Check one: Yes_____ No_____

If yes, list the device(s):_____
Reason for use:_____

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EMERGENCY MEDICAL TREATMENT AUTHORIZATION

Name of Minor: _____

Date of Birth: _____ Age: _____

Street Address: _____

City/State/Zip Code: _____

Parent/Guardian: _____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____

Minor's Gender: _____ Height: _____ Weight: _____

HEALTH INFORMATION

Please indicate below any current health condition(s) 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: _____

Indicate if your child has any of the following conditions:

Yes___ No___ Asthma – Inhaler required at Program

Yes___ No___ Vision Problems – Glasses or Contacts required at Program

Yes___ No___ Hearing Problems – Hearing Aid(s) required at Program

Yes___ No___ Attention Deficit Disorder (ADD) /Attention Deficit Hyperactivity Disorder (ADHD)

Yes___ No___ Other (please specify):_____

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

_____

_____

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Attachment 2

CONFIDENTIALITY POLICY

It is the policy of the *Columbia (MD) Alumnae* Chapter of Delta Sigma Theta Sorority, Incorporated ("Delta") to protect the confidentiality of its youth participants and their families. Except as provided below, the *Columbia (MD) Alumnae* 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 *Dr. Betty Shabazz Delta Academy* program and to better serve the needs of the youth participants, the *Columbia (MD) 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 (i.e., 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 the *Columbia (MD) Alumnae* 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."

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Safekeeping of Confidential Records: The President of the *Columbia (MD) 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, the *Columbia (MD) 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.

Columbia (MD) Alumnae Chapter
Delta Sigma Theta Sorority, Inc.
Dr. Betty Shabazz Delta Academy

Attachment 3

PHOTOGRAPH AND VIDEO AUTHORIZATION AND RELEASE FORM

I/We, _____ ("Parent/Guardian"), as parent(s) or legal guardian(s) of _____, give permission for the *Columbia (MD) Alumnae* Chapter of Delta Sigma Theta Sorority, Incorporated (the "Chapter") to publish on the Internet or media, still photographs or moving images, including if applicable, any sound recordings accompanying the images ("Images") taken of my child at the *Dr. Betty Shabazz Delta Academy* Youth Initiative Program during the *2013 – 2014* program year (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 authorize 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/we waive any right to inspect or approve the finished product wherein my child's likeness appears. Additionally, I/we 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 _____, and do hereby give my/our consent without reservation to the foregoing on behalf of my/our child.

Parent/Guardian Signature: _____

Print Name: _____

Date: _____

Parent/Guardian Signature: _____

Print Name: _____

Date: _____

Columbia (MD) Alumnae Chapter
Delta Sigma Theta Sorority, Inc.
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Attachment 3

DELTA SIGMA THETA YOUTH INITIATIVE SIGN IN/SIGN OUT POLICY

It is the policy of the *Columbia (MD) Alumnae* Chapter of Delta Sigma Theta Sorority, Incorporated that all participants (youths, members, and other volunteers) and visitors must sign-in and out of its *Dr. Betty Shabazz Delta Academy* Youth Initiative Program ("Program"). The required sign in/sign out procedures are as follows:

1. The Chapter shall maintain and use a daily 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/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 initial the attendance sheet.

    c. When the Chapter provides transportation to offsite 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.

The Chapter should clearly communicate to parents or guardians that, 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 *Columbia (MD) Alumnae* Chapter assumes no responsibility or liability for the youth participant for any non-chapter-sponsored activity or transportation.

Columbia (MD) Alumnae Chapter
Delta Sigma Theta Sorority, Inc.
Dr. Betty Shabazz Delta Academy

Attachment 3

YOUTH PICK-UP AUTHORIZATION FORM

I/We authorize the persons listed below to pick-up my child from the *Dr. Betty Shabazz Delta Academy* youth initiatives program. For my/our child's safety, I/we 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/we will notify all authorized persons of this requirement so that they will have photo identification with them when they arrive to pick-up my/our 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/we verify that I/we have read and agree to the Student Pick-Up policies described above and authorize the Columbia (MD) Alumnae Chapter to release my child to the persons listed above. I also agree to notify the Columbia (MD) Alumnae Chapter in writing of any changes to the above list of authorized persons.

Mother/Guardian Signature: _____ Date: _____

Father/Guardian Signature: _____ Date: _____

Columbia (MD) Alumnae Chapter
Delta Sigma Theta Sorority, Inc.
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Attachment 4

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 (e.g., Aleve or Midol), and Aspirin (e.g., Excedrin or Bayer).

_____ **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., Halls or 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: _____

Columbia (MD) Alumnae Chapter
Delta Sigma Theta Sorority, Inc.
Dr. Betty Shabazz Delta Academy

Attachment 4

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: _____

MEDICATION AUTHORIZATION FORM

(To be filled out by the physician dispensing the medication)

Name of Minor: _____ DOB: _____

Medication: _____

Dosage: _____

Time of administration: _____

Reason for medication: _____

Route of administration: _____

Possible side effects and/or other significant information: _____

_____

_____

Physician's Signature: _____

Physician's Printed Name: _____

Physician's Phone Number: _____

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Attachment 4

PARENTAL PERMISSION FORM ADMINISTRATION OF PRESCRIPTION MEDICATION

I/We hereby give permission for _____ to take _____ (medication) 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 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 ("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 determines 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: _____

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Attachment 4

MEDICATION ADMINISTRATION PROCEDURES

Prescription Medication:

1. The Chapter requires 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 its 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 the Chairperson of the Program. The original prescription container should be labeled with the following information: (1) name of student, (2) name of medication, (3) dosage of medication to be given, (4) frequency of administration, (5) route of administration, (6) name of physician ordering medication, (7) date of prescription, and (8) 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 will include 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 will include the student's name, date, time of administration, and dosage.