PRINCE GEORGE'S COUNTY ALUMNAE CHAPTER
DELTA SIGMA THETA SORORITY, INC.
IN PARTNERSHIP WITH THE
DELTA FOUNDATION, INC.

Countdown to College,
2020 Spring Day Tour
of Historically Black Colleges and Universities

Calling 9th and 10th Grade Students

Wednesday, April 8, 2020

7:00AM – 9:00PM

Bus departs from Kettering Plaza in Largo, Maryland
(Parking Lot Closest to Ledo's Pizza and Starbucks)

Observe Campus Life First-Hand at the Prestigious

Virginia State University &
Norfolk State University

Luxury Round-Trip Bus Transportation
Lunch and Dinner on Campus
Guided Tours of Both Campuses
DVDs and Games to Entertain While Traveling

Completed Application & Payment of $50 Due On: Monday, March 23, 2020
Make checks or money orders payable to: PGCAC-DST

Mail payment and application via **Regular U.S. Mail only** to:

Prince George's County Alumnae Chapter (PGCAC)
Delta Sigma Theta Sorority, Inc. – 2020 HBCU SPRING DAY TOUR
P. O. Box 3604
Capitol Heights, MD 20791-3604

For additional information, call (301) 736-3250 or email HBCU@pgcacdst.org
Visit the website (www.pgcacdst.org) to download the application.

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COUNTDOWN TO COLLEGE, 2020 SPRING DAY TOUR of HISTORICALLY BLACK COLLEGES and UNIVERSITIES

REGISTRATION – PARENTAL CONSENT FORM

Type or Print and Use Black Ink Only

PART I – IDENTIFYING AND CONTACT INFORMATION

STUDENT NAME: Last		First	Middle Initial
Street Address:			
City/State/Zip Code:			
Gender: M __ F __ Other __	Date of Birth:	Cell Phone #:	Email Address:
Current School:		Current Grade:	
PARENT/GUARDIAN NAME(S):			
PARENT/GUARDIAN Cell #:	Home Phone #:	Work Phone #:	Email:

PART II – STUDENT AGREEMENT

As a condition of my participation in the HBCU Day Tour, I agree to abide by the Rules of Conduct and adhere to the guidance/directions of the Tour Coordinators/Chaperones.

_____ _____ _____
Student's Name (Printed) Student's Signature Date

PART III – PARENTAL CONSENT

I HEREBY CERTIFY that all statements made herein and on any supplemental forms included as part of this application are true and correct to the best of my knowledge. Additionally, I have read said forms and agree to all terms described therein as well as the following **INDEMNIFICATION:**

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, Inc., 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, Inc., its officers, National Executive Board, employees, members, representatives, agents and assigns.

My signature below and the **enclosed $50 payment** indicate that my student has my permission to participate in the Spring Day Tour of HBCUs sponsored by the Prince George's County Alumnae Chapter (PGCAC) of Delta Sigma Theta Sorority, Inc. in partnership with the Delta Foundation, Inc. (DFI).
I understand that **no monies are refundable**; however, they are transferable to another student.

Parent/Guardian's Name (Printed) _____

Signature: _____ Date: _____

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STUDENT HEALTH FORM (Part I)
THIS FORM MUST BE COMPLETED BY THE PARENT/GUARDIAN

Type or Print Using Black Ink ONLY. Do Not Leave Anything Blank. **Use N/A Where It Applies**. NOTE: This CONFIDENTIAL Information Will Be Used by the Registered Nurse/Health Practitioner and Chaperone(s).

Full Legal Name (Student)_____

☐ **Male** ☐ **Female** ☐ **Other** **Date of Birth** _____ **Age** _____

Street Address _____

City _____ **State** _____ **Zip** _____

PARENT/GUARDIAN CONTACT INFO		
Print Name(s):		
Work Phone #(s)	**Home Phone #(s)**	**Cell Phone #(s)**

Health Insurance Carrier _____

Provide a COPY of Insurance Card

☐ Primary Policy Holder's Name/Policy #

_____

☐ Secondary Policy Holder's Name/Policy #

_____

☐ Military Dependent Policy Holder's Name/Policy #

_____

Print Name of Primary Care Physician _____ **Phone** _____
AREA CODE/NUMBER

EMERGENCY CONTACT		
Print Name and Relationship to Student:		
Work Phone #	**Home Phone #**	**Cell Phone #**

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STUDENT HEALTH FORM (Part II)

Name of Student_____
Date and REASON for last medical exam/Describe in full detail: (i.e., annual physical exam, asthma attack, etc.):

_____

_____

_____

I hereby certify that all statements made herein are correct and true. I will hold harmless the Prince George's County Alumnae Chapter of Delta Sigma Theta Sorority, Inc. and the Delta Foundation, Inc. from any injuries or harm my child may incur due to omissions or false statements given about his/her health.

IN CASE OF EMERGENCY, I HEREBY GIVE MY PERMISSION FOR MEDICAL TREATMENT TO BE GIVEN TO THE ABOVE-NAMED CHILD AS INDICATED BY MY SIGNATURE BELOW:

_____ _____
Parent/Guardian's Signature Date

PRESCRIPTION and OVER-THE-COUNTER MEDICATION CHART
To Be Completed by the Parent or Guardian

List the full names of all of the **Prescription and Over-the-Counter Medications** currently being taken by your child. Copy the information from the containers when completing the following Medication Chart.

********PLEASE BRING ALL MEDICATIONS WITH YOU ********
All Medications must be in original bottles/containers. Write N/A if None Taken.

Name of Medication	Dosage	Frequency Taken	Reason for Taking

LIST ALL ALLERGIES and REACTIONS. Please Indicate N/A If None:

MEDICATION	REACTION	FOOD	REACTION
1		1	
2		2	
3		3	
4		4	

Please provide a photocopy of a valid Health Insurance Card.
In addition, the student MUST bring the actual Insurance Card and a current Photo ID on the Tour.

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STUDENT HEALTH FORM (Part III)
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 in accordance with established protocols developed by the Program.

The following non-prescription 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 cough/sore throat**: Cough drops/lozenges or cough suppressant.

____ **For upset stomach**: Antacid liquid or chewable tablets (e.g., Mylanta)

____ **For sun protection**: Sunscreen lotion

____ **I DO NOT WANT ANY MEDICATIONS GIVEN TO MY CHILD.**

Parent/Guardian Signature _____ Date_____