Delta Sigma Theta Sorority, Inc.
Fort Washington Alumnae Chapter

2018-2019 YOUTH INITIATIVES RISK MANAGEMENT PACKET

FWAC Jabberwock Program

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Program: [ ] Delta Academy [ ] Delta GEMS [ ] Jabberwock

PARENTAL AFFIRMATION

I, ___________________________________ , Parent/Guardian, under penalty of perjury, do hereby affirm to the Fort Washington Alumnae Chapter of Delta Sigma Theta Sorority, Incorporated that I authorize the participation of _______________________ , Participant Minor/Child, in the ___________________ 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 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.

Signature: ____

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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)[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-day suspension from program
4th Time: 2-day 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: 2-day suspension from program
Next occurrence, youth is removed from the program.

[1] Cyber-bullying is defined in Appendix 16, which sets out the *Internet Use Policy*.

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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 (CHILD) 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/his participation in the program. I agree that the sanctions for violating the *Code of Conduct* are reasonable and will help my child comply. In addition, I have read Delta Sigma Theta Youth Initiative Guidelines for Supervising Off-Site Activities ("Youth Initiative Guidelines"). I/We believe that our child is mature enough to follow the Youth Initiative Guidelines and that he/she will act responsibly during all off-site activities.

______________________________ ______________________________

Print Name (PARENT) Signature

____

Date

PLEASE PRINT AND TURN IN SIGNED FORM AT ORIENTATION**

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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 Ph. __________________ Work Ph. __________________Cell Ph. ________________

Name ____ Relationship___________________

Home Ph. __________________ Work Ph. __________________Cell Ph. ________________

Name ____ Relationship___________________

Home Ph. __________________ Work Ph. __________________Cell Ph. ________________

Name ____ Relationship___________________

Home Ph. __________________ Work Ph. __________________Cell Ph. ________________

Name ____ Relationship___________________

Home Ph. __________________ Work Ph. __________________ Cell Ph. _______________

By signing below, I verify that I have read and agree to the Student Pick-Up policies described above and authorize the Fort Washington Alumnae Chapter to release my child to the persons listed above. I also agree to notify the Fort Washington Alumnae 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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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? Yes No

Parent/Guardian Name:____
Does Parent/Guardian live at home with child? Yes No

Is/Has child been under regular supervision of a physician? Yes No
Name and address of physician: _______________________________________
Date of last physical exam: ____

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 this 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 this youth initiatives program? (check one) Yes No
If yes, please provide detailed explanation ____

____

Specify any other serious or severe illnesses or accidents:____
____

Does the child take prescribed medications? Yes No
Name the medications: ____
____

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____

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 the child take any over the counter medications frequently? Yes No
Name the medications:____
Frequency taken: ____

Does child have any allergies? Yes No
Specify: ____

Does the student use any special devices (i.e. hearing aid, cochlear implants, etc.)? Yes No
Name the Device(s): ____

Reason for use:

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EMERGENCY MEDICAL TREATMENT AUTHORIZATION

Name of Minor: ____

Date of Birth:___________________________________ Age: ________

Address: ____

City/State/Zip Code: ____

Parent/Guardian Home Phone:___________________________________

Cell Phone: ____

E-mail Address: ____

Minor's Gender: M F 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 ____
- [ ] Medicine ____
- [ ] Bee sting or insect bite ____
- [ ] Other ____

[ ] Asthma [ ] Inhaler required at Program

[ ] Vision [ ] Glasses [ ] Contact Lenses

[ ] Hearing [ ]Hearing Aid(s)

[ ] ADD / ADHD

[ ] Other: ____

List all medications: ____

____

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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, ____________________ (insert child's name):

[ ] **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., 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 ______________

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: ____

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EMERGENCY CONTACT INFORMATION

Child's Name: ____

Parent/Guardian #1

Name ____________________________________ Relationship ___________________ _____

Street Address ____

City/State/Zip Code _____________________ _ __________________ _ ______________ ______

Home Ph. _________________ Work Ph. _________________ Cell Ph. _______________

E-mail address ____

Parent/Guardian #2

Name ____________________________________ Relationship ___________________ _____

Street Address ____

City/State/Zip Code _____________________ _ __________________ _ ______________ ______

Home Ph. _________________ Work Ph. _________________ Cell Ph. _______________

E-mail address ____

If for any reason I/we cannot be reached, please contact the following person(s) who I/we hereby authorize to seek emergency medical or surgical care for my/our child.

Name ____________________________________ Relationship ___________________ _____

Home Ph. _________________ Work Ph. _________________ Cell Ph. _______________

Name ____________________________________ Relationship _________________ _______

Home Ph. _________________ Work Ph. _________________ Cell Ph. _______________

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 ________________

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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____

Physician's telephone number____

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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 ("Delta"), 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 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 Signature ______________________________________ Date ____________

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MEDICATION ADMINISTRATION

PROCEDURES **Prescription Medication**

1. FWAC 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

   _____________ 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 ______________ Youth Initiatives Program. Medications should be brought to the _____________ 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 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.

[1] A copy of the Emergency Medical Treatment Authorization is attached hereto Appendix 18

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DELTA SIGMA THETA YOUTH INITIATIVE SIGN IN/SIGN OUT POLICY

It is the policy of the Fort Washington Alumnae Chapter, Delta Sigma Theta Sorority, Incorporated that all participants (youths, members, and other volunteers) and visitors must

sign-in and out of its Youth Initiative Program ("Program"). The required sign in/sign out procedures follow:

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 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.

If a parent or guardian wishes to arrange alternative transportation for their child to attend an off site activity, the youth may join the group at the event or activity, but the Fort Washington Alumnae Chapter assumes no responsibility or liability for the youth participant for any non-chapter-sponsored activity or transportation.

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PHOTOGRAPH AND VIDEO AUTHORIZATION AND RELEASE FORM

I/We, ______________________________________ ("Parent/Guardian"), as parent(s)

or legal guardian(s) of _______________________, give permission for Fort Washington 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 Youth Initiative Program sessions, 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 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 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.

________________________________ ________________________________

Print Name Signature

____

Date