



Delta Sigma Theta Sorority, Incorporated
Quaker City Alumnae Chapter
www.DSTQuakerCity.org



2018 – 2019 Toy Library Program Application

Toy Library was created to fill the urgent need to expand cultural awareness and to enhance reading skills of underprivileged and/or underperforming youth ages 5-11 years old in Philadelphia.

Important Dates & Information	
Parent/Participant Orientation Meeting	Saturday, September 15, 2018 at 11:00am African American United Fund 2227 N. Broad Street, Philadelphia, PA 19132
All regularly scheduled meetings are (with a few pre-determined exceptions - parents will be notified)	11am – 1pm on the 3rd Saturdays of the month September 2018 – June 2019
Meeting Address (unless otherwise noted)	African American United Fund 2231 N. Broad Street Philadelphia, PA 19132

Behavior Policy

Students must comply with the rules and regulations established by Delta Sigma Theta Sorority, Inc., Quaker City Alumnae Chapter, and the Toy Library program.

Attire

Participants should look neat (hair included) wearing appropriately fitted pants, skirts /dresses (modest length) and comfortable shoes. Please, NO midriff tops, low rise or ripped pants or shirts with “distracting” logos/language.

For field trips: The official Toy Library shirts must be worn with aforementioned appropriate bottoms and comfortable walking shoes.

Costs - The cost of this program is FREE.

<p>Mailing Address: Delta Sigma Theta Sorority, Inc. Quaker City Alumnae Chapter Attn: Toy Library P.O. Box 42831 Philadelphia, PA 19101</p> <p>Chapter President: Dr. Claudette W. Stone QuakerCityPresident@gmail.com</p>	<p>For More Information: Toy Library Chairpersons Marcella Blakney-Collins (267) 205-8014 Sherrie Lane (215) 279-1880 Calische Gully (267) 515-3401</p>
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2018 - 2019 Application

PLEASE TYPE OR PRINT ALL INFORMATION

<i>Student's Personal Information</i>			
Student Name (First, Middle Initial, Last)		Date of Birth:	Gender:
			Grade:
Address: (Number, Direction, Street, Apt #)		City/State	Zip Code
Home Telephone: ()	Cell Phone: ()	Email Address:	
School Name:	School Address:		
<i>Family/Contact Information</i>			
Parent/Legal Guardian Name:	Cell Phone: ()	Work Telephone: ()	
Parent/Legal Guardian Email Address:			
T-Shirt Size _____ (S, M, L, XL, XXL)			
Parental/Legal Guardian Release			
<p>I give permission for my child to be a part of the Delta Sigma Theta Sorority Inc., Quaker City Alumnae Chapter's Toy Library Program. I agree by signing this form that my child will comply with the established Toy Library rules and instructions for student behavior. I also agree that Quaker City Alumnae Chapter has the right to enforce appropriate Standards of Conduct and that, at any time during our programming, Quaker City Alumnae Chapter has the right to terminate my child's participation for failure to abide by the Standards of Conduct, or for any actions which the Coordinators deem incompatible with the interest, harmony, comfort and welfare of other participants.</p>			

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I hereby release Delta Sigma Theta Sorority, Inc., Quaker City Alumnae Chapter, and its agents or assigns from any and all liability relating to any physical injury which may occur as a result of my child's direct or indirect participation in activities conducted under the supervision and directions of Delta Sigma Theta Sorority, Incorporated and Quaker City Alumnae Chapter.

In the event reasonable attempts to reach me are unsuccessful, I hereby give my consent for medical or dental treatment deemed necessary to be administered to my child. I agree to release Delta Sigma Theta Sorority, Incorporated and Quaker City Alumnae Chapter from any and all liability associated with the care and treatment of my child.

I understand all the rules and regulations of the program, and agree to abide by them. I promise to be an active participant/supporter of my child in this enrichment program.

Parent/Guardian Printed Name:	<input checked="" type="checkbox"/> Parent/Guardian Signature:	Date Signed:
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PHOTOGRAPH, MEDIA AND VIDEO AUTHORIZATION RELEASE FORM

I/We, _____ (“Parent/Guardian”), as parent(s) or legal guardian(s) of _____, give permission for _____ 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 during participation in _____ Youth Initiative Program activities, without payment or any consideration and without notifying me in advance.

I/We also give permission for the Chapter to highlight my child’s achievements and activities in efforts to promote the youth initiative program through newspapers, radio, TV, the web, DVDs, displays, brochures, and other types of media 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 **Toy Library 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 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 _____, authorized legally to give this consent, and do hereby give my/our consent without reservation to the foregoing on behalf of my/our child.

Parent/Guardian Signature

Date

Print Name

Parent/Guardian Signature

Date

Print Name

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YOUTH PICK-UP AUTHORIZATION FORM

I authorize the persons listed below to pick-up my child _____ from the *Quaker City 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 **Quaker City Alumnae Chapter** to release my child to the persons listed above. I also agree to notify the **Quaker City 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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APPENDIX 22

DELTA SIGMA THETA YOUTH INITIATIVE SIGN IN/SIGN OUT POLICY (COPY GIVEN TO PARTICIPANTS)

It is the policy of the *Quaker City Alumnae* Chapter, Delta Sigma Theta Sorority, Incorporated that all participants (youths, members, and other volunteers) and visitors must sign-in and out of its *Quaker City Alumnae* Chapter's 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 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.

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 *Quaker City Alumnae* Chapter assumes no responsibility or liability for the youth participant for any non-chapter-sponsored activity or transportation.

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APPENDIX 15

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 *Quaker City Alumnae Chapter* 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

Parent/Guardian Signature Date

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APPENDIX 17

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 at home with child? _____

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

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 the Quaker City Alumnae 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 Quaker City Alumnae youth initiatives program?

(check one) Yes No

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If yes, please provide detailed explanation _____

Specify any other serious or severe illnesses or accidents: _____

Does child take prescribed medications? Yes No

Name the medications: _____

Frequency Taken: _____

(For any medications or treatment required during the course of the *Quaker City Alumnae* 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 the medications: _____

Frequency Taken: _____

Does child have any allergies? Yes No

Specify: _____

Does the student use any special device(s) (i.e. hearing aids, cochlear implants, etc.): Yes No

Name the Device(s): _____

Reason for use: _____

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APPENDIX 18

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 _____ 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 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: _____

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Child's Name: _____

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., 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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Child's Name: _____

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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APPENDIX 19

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 _____	

PARENTAL PERMISSION FORM
ADMINISTRATION OF PRESCRIPTION MEDICATION

I/We hereby give permission for _____ to take _____ at the *Quaker City Alumnae* 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 *the Youth Initiative's Chair(s)* 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 *Quaker City Alumnae* 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 *Quaker City Alumnae* youth initiatives program reserves the right to refrain from administering medication if in the judgment of the *Quaker City Alumnae* 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 *Quaker City Alumnae* youth initiatives program by me/us in the original appropriately labeled container. If I/we cannot bring the medication to the *Quaker City Alumnae* youth initiatives program, I/we will call the *Quaker City Alumnae* 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 _____

I do **NOT** want Delta Sigma Theta Sorority, Incorporated ("Delta"), its officers, National Executive Board, employees, members, local chapters, representatives, agents, affiliates, assigns, the *Quaker City Alumnae* youth initiatives program, its agents, and/or any employee to administer any drug to my/our child. Nor will I hold any of the aforementioned liable for any damages.

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Parent/Guardian's Signature _____ Date _____

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 *Quaker City Alumnae* Chapter's 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 *Quaker City Alumnae* Chapter's youth initiatives program. Medications should be brought to the *Quaker City Alumnae* Chapter's youth initiatives program by the parent or responsible adult and taken to *the Youth Initiative's Chair(s)*. 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 _____ day(s) 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 *Quaker City Alumnae* 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.