# YOUTH MENTAL HEALTH SUMMIT

*Valencia College West ( HSB building)- September 23, 2017*

Please print in blue or black ink or type. Please provide all requested information.

## 13 Reasons Why NOT!

| | |
|---|---|
| **Topic I** | Bullying/ Cyber Bullying/Spectator Behavior |
| **Topic II** | Wrap Group/Intervention |
| **Topic III** | Depression and Suicide |
| **Topic IV** | Anger Management/Aggression |
| **Topic V** | Interaction with Authoritarian figures |
| **Topic VI** | Self-Esteem/Healthy Relationships/Human Trafficking |
| **Finale** | **Parent Panel Discussion:** Recognizing Signs of Mental Illness / Suicide/Depression/Cyberbullying/Bullying/Human Trafficking/ It's a Different World from Where We Come From/ Street Drugs (Substance Abuse) * Parents are highly encouraged to attend |

## APPLICANT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| First Name | Middle Name | Last Name | Date of Birth | Male | Female |
| Street Address | City | State | Zip | | |
| Home Phone | Cell Phone | E-mail Address | | | |
| Best Point of Contact | Phone | | | | |
| High School Attending | Academic Year | GPA | Graduation Date | | |

## PARENT / GUARDIAN INFORMATION Complete for one parent or legal guardian, both if available.

| | | | |
|---|---|---|---|
| Name of Mother/Legal Guardian | Will you attend the summit Yes No | | |
| Address (if different from applicant's) | City | State | Zip |
| Mother/Legal Guardian Work Phone | Mother's Home/Cell Phone | Email | |

| | | | |
|---|---|---|---|
| Name of Father / Legal Guardian | | | |
| Address (if different from applicant's) | City | State | Zip |
| Father's /Legal Guardian Work Phone | Father's Home/Cell Phone | Email | |

## EMERGENCY CONTACT INFORMATION

| First Name | Middle Name | Last Name | Relationship |
|---|---|---|---|
| | | | |

| Street Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Home Phone | Cell Phone | E-mail Address |
|---|---|---|
| | | |

## MEDIA PERMISSION FORM

___ I hereby grant permission to use my child's name, _____, picture and comments in materials (television, video, and world-wide web, audio and printed media) used for healthy promotion and documentation.

___ I do not give such permission.

## SPECIAL MEDICAL NEEDS

Are there any specific or special medical needs that we should be aware of for your child? Please list them below along with any information that could be helpful.

Allergies: _____

_____

Special Needs: _____

_____

Family Physician: _____ Contact Number: _____

Preferred Hospital/Health Care Facility: _____ Location: _____

In the event of injury, I release Orlando Alumnae Chapter of Delta Sigma Sorority, Inc., and Youth Summit partners From any and all claims. I give permission for the person in charge to seek medical services if needed.

Parent Signature_____Date_____A

## PARENT / GUARDIAN PERMISSION

This section must be completed and signed by a parent or guardian, not a student.

As parent / guardian of the above-named child, I give permission to participate in the activities of Orlando Alumnae Chapter of Delta Sigma Sorority, Inc. Mental Health Youth Summit on Saturday, September 23, 2017 at Valencia College West. I release all partner organizations and its representatives from any liability in the event of an accident en-route, during, or returning from an activity. I also authorize them to obtain any emergency medical attention that may be required during my child's attendance.

| **Signature of Parent / Legal Guardian** | **Date** |
|---|---|
| | |

**Please complete and email to healthandwellness@oacdst.org or mail to OACDST PO Box 555238 Orlando, Florida 32855. This must be returned or accompany the youth in order to attend. Registration available on Site.**