



YOUTH MENTAL HEALTH SUMMIT



Valencia College West (HSB building)- November 11, 2017

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

Registration deadline: November 4, 2017

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, November 11, 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.