Verizon Innovative Learning for Minority Males Program
directed by Hampton University

Application package includes the following
- Pre-registration (online: https://www.nacce.com/vil19regformboys)
- Hampton University Application form
  - Health Form
  - Verizon Consent form
- Informational parent/guardian letter

For additional information contact the Program Manager at
vilmmhu@gmail.com or vilmmhu@hamptonu.edu

Or by mail:
Verizon Innovative Learning for Minority Males Program
c/o Ms. Marci Turner
Verizon Innovative Learning Program
School of Engineering & Technology
Hampton University
Hampton, VA 23668
757-727-5937
Dear Parent/Guardian of Verizon Innovative Learning for Minority Males Program Participant:

We would like to share information that will help as you apply for the three week Verizon Innovative Learning Program at Hampton University, a non-residential program. Please read this letter completely and sign and return the Participant Behavior Contract.

Your main responsibility is to make sure your child is available and attends the program at Hampton University daily for the duration of the summer program session. The summer program is scheduled for June 17 – July 5, 2019 from 8:00am – 4:30pm. Transportation to/from Hampton University will be provided for Hampton and Newport News City Public School students. You are also invited to the program orientation on June 16, 2019 (2:30pm – 5pm), and closing program scheduled for July 5, 2019.

Instructions:
- All participants are expected to attend the entire program
- In case of emergency, the designated person or parents will be contacted for immediate pickup
- Breakfast and a lunch will be provided each day. Notify us of special dietary needs (in case of stringent dietary needs, feel free to send your child with lunch)
- Hampton University is a walking campus so encourage students to dress comfortably
- Participants are expected to participate in all activities and stay with the group.
- Never should a student be alone on campus
- All program fees (including technology) are covered and free of charge to you
- Transportation: if your child is living at a different address than the official school address, you will need to arrange your own transportation and notify us. (Transportation available for Hampton and Newport News Public School students)
- All participants are expected to engage in the program through the 2019-2020 academic year (meeting once a month on Saturdays)

Please be advised that we are not responsible for lost or stolen items.

Rules of the Program
- Respect individual differences (be a team player)
- Respect mentors and staff
- Take note of the schedule and plan accordingly (*To be early is to be on time and to be on time is to be late*)
- Full participation in all events is expected (cell phone/iPod/iPad use is unacceptable during workshops/teamwork unless directed to use)
- Respect dress code (see dress code statement)
- Unacceptable behavior will result in the following
  1. First offense- verbal warning
  2. Second offense- additional work as assigned by mentors/staff
  3. Third offense- parent pickup

*** Depending on the severity of offense, penalty could immediately escalate beyond verbal warning
Dress Code

Students will be denied admission to various functions if their manner of dress is inappropriate. On this premise students at Hampton University are expected to dress neatly at all times. The following are examples of appropriate dress:

1. Classroom, Cafeteria, Student Union and University offices - neat, modest, casual attire.
2. Field Trips- Students are expected to dress comfortable or wear their program issued t-shirt on field trip days if provided.
3. Closing Ceremony - Students are expected to wear business casual attire.

Examples of inappropriate dress and/or appearance include but are not limited to:

1. Do-rags, stocking caps, skullcaps and bandanas are prohibited at all times on the campus of Hampton University.
2. Head coverings and hoods for men in any building.
3. Baseball caps and hoods for women in any building.
4. This policy item does not apply to headgear considered as a part of religious or cultural dress.
5. Midriffs/halters, mesh, netted shirts, bare feet, short shorts, tube tops or cutoff tee shirts in classrooms, cafeteria, Student Center, and offices;
6. Clothing with derogatory, offensive and/or lewd messages either in words or pictures;
7. Men's undershirts of any color worn outside of the private living quarters of the residence halls. However, sports jerseys may be worn over a conventional tee-shirt.
8. Pants worn below the belt line are unacceptable
9. Students seeking approval to wear headgear as an expression or religious or cultural dress may make a written request for a review through the Office of the Chaplain.

CONTACT INFORMATION

If you have any questions or concerns you may contact us by email or phone:

Program Manager
vilmmmhu@gmail.com
vilmmmhu@hamptonu.edu

Ms. Marci Turner
Program Director
Office: 757-727-5937

Dr. Otsebele Nare
Program Co-PI
Office: 757-727-5818
VERIZON INNOVATIVE LEARNING FOR MINORITY MALES PROGRAM

PARTICIPANT BEHAVIOR CONTRACT

• I will respect others and myself.
• I will not use offensive language or profanity.
• I will have a good attitude and be considerate to all staff and other students.
• I will be responsible for my own behavior and will not engage in behavior that will physically hurt anyone or myself.
• I will not engage in behavior that will damage, destroy or misuse any personal or program property.
• I will not engage in roughhousing or any other behavior that disrupts the program.
• I will not turn on any unauthorized electronic device, including a cell phone, during class sessions.
• I will participate and put forth my best effort in all activities.
• I will follow ALL directions given by staff, volunteers or other adults.

CONSENT: We have read the above letter and rules; agree to abide by them; and understand that a violation will result in immediate removal from the program.

________________________  ___________________________  ______________________
Student Name (PRINT)        Student Signature              Date

________________________  ___________________________  ______________________
Parent/Guardian Name (PRINT)  Parent/Guardian Signature  Date

Middle School Name: ___________________________________________
VERIZON INNOVATIVE LEARNING FOR MINORITY MALES

Are you pre-registered online? (https://www.nacce.com/vil19regformboys)

APPLICANT INFORMATION

Name: __________________________________________   Date of Birth: _____/_______/______

Ethnicity: [ ] African American   [ ] Hispanic   [ ] Other Minority, please specify _____________

Street Address: ________________________________   Unit/Apt #: _____________

City: _______________________    State: ________________   Zip Code: ______________

Home Phone: (_____) ______________  Cell Phone: (_____) ______________

Email Address: ________________________________________________

Current Middle School: ____________________________________________   CUM GPA: _____/_____

Address: _____________________________________________________________________________

PARENT/GUARDIAN INFORMATION

Name(s): __________________________________________   Relation: _______________________

Street Address: ________________________________   Unit/Apt #: _____________

City: _______________________    State: ________________   Zip Code: ______________

Home Phone: (_____) ______________  Cell Phone: (_____) ______________

In Case of Emergency, in addition to person(s) listed above, contact:

Name(s): __________________________________________   Relation: _______________________

Address: _____________________________________________________________________________ Phone: (_____) ______________
TELL US MORE

We are interested in knowing more about your interest in STEM. Participation in specific activities is NOT a prerequisite for attending the program. Answer the questions to the best of your ability.

*Have you taken any particular courses that have piqued your interest in Science, Technology, Engineering, or Math (STEM)?*

_____________________________________________________________________________________
_____________________________________________________________________________________

*Do you participate in any STEM clubs or organizations?*

_____________________________________________________________________________________
_____________________________________________________________________________________

*Do you follow STEM news on a regular basis?*

_____________________________________________________________________________________

*Have you participated in any business, engineering or technology competitions? Please list them.*

_____________________________________________________________________________________
_____________________________________________________________________________________

*Is there anything else you would like us to know about you?*

_____________________________________________________________________________________

_________________________________________  ______________________________
Applicant Signature                             Parent/Guardian Signature (required)

_________________________________________  ______________________________
Applicant Email Address (required)                  Parent/Guardian Email Address

____________________________         _______________________
DATE                                     DATE
GENERAL RELEASE

I grant Verizon Communications Inc., its subsidiaries, successors, assigns, and licensees (collectively “Verizon”) the following rights:

1. I grant Verizon the right to take photographs and videos of me and my likeness and record or otherwise take my voice for testimonials and other statements (“Photography”) on the date and at the location listed below.

2. I also grant Verizon the right to edit and use the Photography in any way whatsoever, for any purpose, and in any manner and medium, including but not limited to, advertising, publicity or promotional material, in print, video, television, radio, or any other media, electronic or otherwise, including websites and the Internet, at any time or times throughout the world, to use quotations and soundtrack recordings of me or my voice, including the right to substitute the voice of another person(s) for my voice, to use my name or a fictitious name and biographical and other information, accurate or fictitious, concerning me in connection with the use of the Photography.

3. I waive any right to inspect or approve the Photography or how the Photography is used and further waive any claim that I may have with respect to its use.

4. I acknowledge that I will not receive any compensation other than any publicity that I may receive relating to the use of the Photography.

5. I forever release and discharge, and agree to hold harmless Verizon and its directors, officers, agents, employees, shareholders and representatives from any and all liability for any violation of any personal rights (including right of privacy and right of publicity), intellectual property rights or any other rights which I may have arising out of or in connection with Verizon’s use of the Photography.

6. I represent and warrant that I am of full age and have every right to contract in my own name in the above regard. This agreement shall be binding upon me, my heirs, legal representatives and assigns.

Location and date: _____________________________________________________________________

I hereby agree and consent:

<table>
<thead>
<tr>
<th>Printed Name</th>
<th>Signature</th>
<th>Address</th>
<th>Date</th>
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</thead>
</table>

If a minor: I am the (parent/legal guardian) of the named minor. I agree and consent to the foregoing on behalf of the minor and personally join in the warranties and representations above. I also agree to indemnify and hold harmless Verizon against any claims the minor may make as a result of Verizon’s use of the Photography as described above.

<table>
<thead>
<tr>
<th>Printed Name of Minor</th>
<th>Printed Name of Parent/Legal Guardian</th>
<th>Signature of Parent/Legal Guardian</th>
<th>Address</th>
<th>Date</th>
</tr>
</thead>
</table>
Hampton University
132 William R. Harvey Way • Hampton, Virginia 23668 • Phone (757) 727-5315 • Fax (757) 728-6612 • Email: healthcenter@hamptonu.edu

Special Program - Medical Clearance Form

Name of Special Program ________________________________

Start Date of Special Program ___________________________ HU ID# (if applicable) ____________________________

PLEASE PRINT OR TYPE

PERSONAL

Date:

Name _____________________________

Address ___________________________

Telephone Number ______________________ Street __________________________ Date of Birth ______________________

Name and relationship of emergency contact

Name _____________________________

Relationship ___________________________

Telephone Number ______________________

PARENTAL CONSENT FOR MINORS

I give my consent for _______________________ to receive the medical care available to Special Program students. In the event that emergency treatment is required and I am not available, I give my consent for the program director, their representative or other HU official (i.e., Health Center, V.P. for Student Affairs, etc.) to approve of necessary treatment and/or hospitalization. I understand that such treatment will be at my expense.

Signature _____________________________ Date ______________________

Insurance Provider _____________________________ Policy Number/ Group Number _____________________________

The following questions are designed to protect YOUR HEALTH.

Personal History (Check all that apply)

A. Have you ever had (or have now):

☐ Dizziness ☐ Seizures ☐ Racing of heart or palpitations
☐ Severe headaches ☐ Chest Pain ☐ Asthma
☐ Fainting or near fainting ☐ Wheezing or coughing ☐ Depression/Anxiety

B. List any frequently taken medicines (prescribed or over the counter):

_____________________________

C. Do you have any food or medication allergies? If so, please explain.

____________________________________________________

Past History (Check all that apply) Have you ever been told of having or advised of any of the following:

☐ Heart murmur(s) ☐ Sickle cell trait or anemia ☐ Heat exhaustion
☐ High blood pressure ☐ Severe sprains ☐ Fractures
☐ Heart failure ☐ Marfan’s Syndrome ☐ Severe ligament injuries
☐ Kidney disease ☐ Concussion ☐ Other ligament injuries
☐ Protein or blood in the urine ☐ Other head injuries ☐ Other lung disease
☐ Other heart disease ☐ Asthma

Family History (Check all that apply) Has any parent, grandparent, sister or brother had any of the following:

☐ Died before age 50 (cause if known) ☐ Heart attack ☐ Heart failure

☐ High blood pressure ☐ Sickle cell trait or anemia ☐ Marfan’s syndrome

Submit Form to Health Center

Signature _____________________________ Participant/Guardian

Number Street City State Zip Code

Area Code

Last  First Middle Initial

Policy Number/ Subscriber Name Group Number

Date of Birth ________________

Name and relationship of emergency contact

Name _____________________________

Relationship ___________________________

Telephone Number ______________________

Date: ______________________

Parent(s)/Guardian _____________________________
Name ____________________________________________________________________________

Last                      First                      Middle Initial

Height ___________________  Blood Pressure _______________________

Weight ___________________  Pulse ________________________________

<table>
<thead>
<tr>
<th>Normal</th>
<th>Check in appropriate column. (Enter NE if not evaluated)</th>
<th>Abnormal</th>
<th>Notes: Describe abnormality. (Enter item number before each comment.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Head, face, neck and scalp.</td>
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<tr>
<td>2. Nose</td>
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<td>3. Mouth and throat</td>
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<tr>
<td>4. Ears – general</td>
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<tr>
<td>5. Eyes – general</td>
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<tr>
<td>6. Chest – general</td>
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<td>7. Lungs</td>
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<tr>
<td>8. Breasts</td>
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<tr>
<td>9. Cardiovascular System</td>
<td></td>
<td></td>
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<tr>
<td>10. Abdomen (include hernias)</td>
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<td>11. Genitalia</td>
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<tr>
<td>12. Upper extremities</td>
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<tr>
<td>13. Lower extremities</td>
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<td>14. Spine</td>
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<td></td>
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<tr>
<td>15. Skin and lymphatics</td>
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</tbody>
</table>

16. Remarks and pertinent history related to P.E. findings (Place supporting item numbers by diagnosis)

17. Recommendations – Further specialist examinations indicated (specify)

18. Examinee (check one)

[ ] is qualified for athletic participation

[ ] is not qualified for athletic participation

Typed or printed name of reviewing physician | Signature (examiner) (MD, DO, NP, PA) | Date

- 2 -
**IMMUNIZATION RECORD**

*Immmunity is required prior to registration. Please complete and return this form.*

Name ____________________________________________________________  

**Last**  **First**  **Middle Initial**

**TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER (Dates must include month and year.)**

*A. TETANUS-DIPTHERIA (Required)*

1. ☐ Completed primary series of tetanus-diptheria immunizations ................................................................. MONTH DATE YEAR  
2. ☐ Received tetanus-diptheria booster (required every 10 years) ................................................................. MONTH DATE YEAR  
3. ☐ Tdap (preferred) to replace single dose of Td for booster immunization with at least five years since last dose of Td ........................................................................................................ MONTH DATE YEAR

*B. MMR (Measles, Mumps, Rubella) (Required) – Two doses required at least 28 days apart.*

1. ☐ Dose 1 – Immunization date required at exactly 12 months or after and before 5 years ................ MONTH DATE YEAR  
2. ☐ Dose 2 – Immunized at 5 years or later .................................................................................................. MONTH DATE YEAR

*C. TUBERCULOSIS – Interpretation based on mm of induration. Check appropriate box.  *(REQUIRED OF INTERNATIONAL STUDENTS ONLY)*

1. ☐ PPD (Mantoux) test within the past year (Tine or monovac not acceptable)  
   Give date placed .................................................................................................................. DATE  
   Give date read and results (based on millimeters) .................................................. DATE  
   mm Result: ☐ Positive ☐ Negative

2. ☐ Positive PPD – Chest x-ray required or IGRA results *(Please Attach).*  
   Give date and result of chest x-ray ............................................................................... DATE

3. ☐ Had BCG vaccine – Chest x-ray required if PPD not done or IGRA results *(Please Attach).*

*D. POLIO*

1. ☐ Completed primary series of polio immunization ...................................................... ☐ Yes ☐ No  
   Type of vaccine: ☐ OPV ☐ IPV  
   Last booster .................................................................................................................. MONTH DATE YEAR

*E. MENINGOCOCCAL MENINGITIS TETRAVALENT (Required A, C, Y, W-135 Groups)*

One dose must be given at age 16 or later.
All adolescents and teens ages 11-18 should be vaccinated, as should unvaccinated adults who are attending college.
Requirements are based on current CDC guidelines.

A booster dose is required for those who received their first dose before age 16:

☐ Menactra ........................................................................................................................................ MONTH DATE YEAR  
或
☐ Menveo ........................................................................................................................................ MONTH DATE YEAR  
或
☐ Menomune ........................................................................................................................................ MONTH DATE YEAR

*F. ☐ HEPATITIS B (Required or Must Sign Waiver)*

Hepatitis B Waiver: I have reviewed the CDC website regarding Hepatitis B @ http://www.cdc.gov/hepatitis/index.html and have been fully informed of the risks and health hazards of Hepatitis B infection as well as the benefits of the Hepatitis B vaccine. I choose not to be immunized against the Hepatitis B infection at this time. I am aware that the shot is available at my local health department or retail pharmacy. Student signature (if under 18, parent or guardian must sign here):

Signature __________________________________________________________________________ Date __________

**HEALTH CARE PROVIDER**

Name ____________________________________________________________  
Address __________________________

Signature ______________________________________ Date __________ Phone (____) __________________

HC (Revised 01/19)