



**SBC-2 – MEMBERSHIP APPLICATION FORM**  
(AS OF 12/1/2019)  
FORM SUBJECT TO CHANGE

National Sigma Beta Club Foundation, Inc.  
Attn: Membership/Finance  
3313 Government Street - Baton Rouge, Louisiana 70806  
Website: [www.sigmabetaclub.org](http://www.sigmabetaclub.org)

**NOTE: Parents/Guardians, submit forms to SBC Chapter Coordinator**

**Please Print or Type Application:**

Date: \_\_\_\_\_ Chapter: \_\_\_\_\_ Region: \_\_\_\_\_

SBC Member Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

SBC Email address: \_\_\_\_\_ SBC Cell Phone #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Name of School: \_\_\_\_\_

Grade Level: \_\_\_\_\_ Cumulative GPA.: \_\_\_\_\_ on a \_\_\_\_\_ scale \_\_\_\_\_

**Parental Information:**

Mother Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone#: (home) \_\_\_\_\_ (cell): \_\_\_\_\_ (work): \_\_\_\_\_

Email address: \_\_\_\_\_

Father Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone#: (home) \_\_\_\_\_ (cell): \_\_\_\_\_ (work): \_\_\_\_\_

Email address: \_\_\_\_\_

Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone#: (home) \_\_\_\_\_ (cell): \_\_\_\_\_ (work): \_\_\_\_\_

Email address: \_\_\_\_\_

Please maintain a copy for your chapter and club files.



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**Emergency Contact List**

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**SBC Member's Name:** \_\_\_\_\_

**In Case of Emergency, please contact:**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Phone Number:**    **home:** \_\_\_\_\_

**work:** \_\_\_\_\_

**cell:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Phone Number:**    **home:** \_\_\_\_\_

**work:** \_\_\_\_\_

**cell:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Phone Number:**    **home:** \_\_\_\_\_

**work:** \_\_\_\_\_

**cell:** \_\_\_\_\_

Please maintain a copy for your chapter and club files.



**SBC-3 – PARENTAL  
CONSENT FORM**  
(AS OF 12/1/2019)  
FORM SUBJECT TO CHANGE

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**NOTE: Parents/Guardians, submit forms to SBC Chapter Coordinator**

**Please Print or Type Application:**

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Date: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

SBC Member Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Parent Phone#: (home) \_\_\_\_\_ (cell): \_\_\_\_\_ (work): \_\_\_\_\_

Parent's Email address: \_\_\_\_\_

I/(We), give permission for our son, \_\_\_\_\_  
as named above, to participate in the Sigma Beta Club, National Sigma Beta Club Foundation. In addition,  
I/(We), the parent(s) of the above-named youth do hereby authorize any treatment or emergency care  
needed for said child by any licensed nurse, physician, or hospital while participating in the approved  
activities of the Sigma Beta Club either sanctioned by the sponsored \_\_\_\_\_ Chapter or  
the National Sigma Beta Club Foundation.

As the parent(s)/next of kin and guardian of said minor, I/(We), forever release, acquit and discharge  
National Sigma Beta Club Foundation, Board Members and Officers, his affiliate SBC club, its officers and  
advisors, and Phi Beta Sigma Fraternity, Inc. its Board Members and Officers, from all liabilities, claims, and  
causes of action which I/(We) or my/(our) representatives may have by reason of said emergency care.

**Please maintain a copy for your chapter and club files.**



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**Medical Information (Please Print or Type Application): SBC Members Name:** \_\_\_\_\_

My/Our child covered by:

Insurance company: \_\_\_\_\_

Policy number: \_\_\_\_\_

Effective from: \_\_\_\_\_ to \_\_\_\_\_

Known medication:

\_\_\_\_\_  
\_\_\_\_\_

Known Allergies: \_\_\_\_\_

Doctor/Physician's Name: \_\_\_\_\_

Contact Number: (main) \_\_\_\_\_ (fax) \_\_\_\_\_

Contact E-mail Address: \_\_\_\_\_

**Parent/Guardian Signature(s):**

Print: \_\_\_\_\_ Sign: \_\_\_\_\_ Date: \_\_\_\_\_

**Notary Information:**

Print: \_\_\_\_\_ Sign: \_\_\_\_\_ Date: \_\_\_\_\_

Subscribe and sworn before me \_\_\_\_\_ DAY OF \_\_\_\_\_, 20\_\_\_\_

Notary Public, State of \_\_\_\_\_ My Commission Expires \_\_\_\_\_



**affix here**