



DELTA SIGMA THETA SORORITY, INCORPORATED  
RANCOCAS VALLEY ALUMNAE CHAPTER

DR. BETTY SHABAZZ DELTA ACADEMY

*“Cherish your visions and your dreams, as they are the children of your soul; the blueprints of your ultimate achievements.”*

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October 1, 2008

Dear Parent/Guardian:

The Rancocas Valley Alumnae Chapter of Delta Sigma Theta Sorority, Inc. would like to extend an invitation to your daughter to participate in the Dr. Betty Shabazz Delta Academy. As one of our Sorority's National Programs, the academy is designed for young ladies ages 11 to 14 and places emphasis in the areas of science, mathematics, and technology. Through participation in workshops, cultural activities, and teambuilding activities, the program promotes talent development and social skill development while building self-esteem and leadership skills.

If you would like your daughter to become a part of this rewarding experience, please complete the enclosed application packet in its entirety (application, parent consent, consent to photograph, and student health history). The packet should be returned to address below. **The deadline for applications is Friday, October 31, 2008.** If you have any questions, please feel free to contact Ms. Jennifer Carroll, Committee Co-Chair, @ (267) 978-5113. Please mail completed application forms by October 31, 2008:

Ms. Jennifer Carroll  
Delta Sigma Theta, Inc.  
Rancocas Valley Alumnae Chapter  
P.O. Box 262  
Rancocas, NJ 08073-262

Sincerely,

Mildred L. McCalpine, President

Jennifer Carroll, Co-Chair



**DELTA SIGMA THETA SORORITY, INCORPORATED  
RANOCOCAS VALLEY ALUMNAE CHAPTER**

**DR. BETTY SHABAZZ DELTA ACADEMY**

**APPLICATION FORM  
2008-2009**

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

Student Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Current Grade: \_\_\_\_\_

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

City, State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

School Name: *(Please give FULL name)*

\_\_\_\_\_

City, State: \_\_\_\_\_

Favorite School Subjects: \_\_\_\_\_

\_\_\_\_\_

Extra-Curricular Activities: \_\_\_\_\_

\_\_\_\_\_

Hobbies: \_\_\_\_\_

\_\_\_\_\_

Your Talents (*What you do best and/or most like to do*):

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What do you want to get from participating in the Dr. Betty Shabazz Delta Academy?

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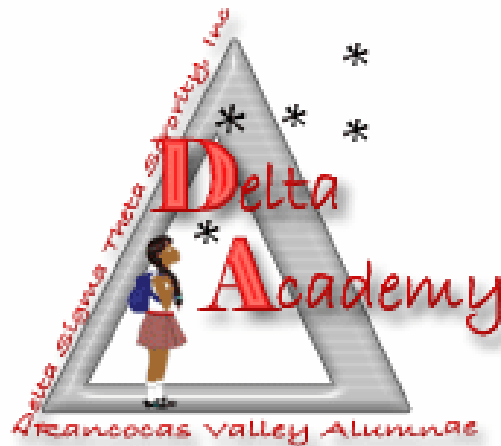
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Which school subject do you need help with most? \_\_\_\_\_ Science \_\_\_\_\_ Math

What new subject would you like to learn about? \_\_\_\_\_

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**Student Signature and Date**





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**PARENT CONSENT FORM  
2008-2009**

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

Relationship: \_\_\_\_\_

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

City, State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

E-Mail Address (*home or work*): \_\_\_\_\_

How did you learn about the Shabazz Delta Academy? \_\_\_\_\_

\_\_\_\_\_

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Delta Sigma Theta Inc. Connection:

Are you a member of Delta Sigma Theta Sorority, Inc.?  Yes  No

If active, please provide Chapter name:

\_\_\_\_\_

Is a relative a member?  Yes  No If yes, relationship: \_\_\_\_\_

If active, please provide Chapter name

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By my signature below, I hereby verify that the above information is accurate. My signature grants permission for my child to participate in the Dr. Betty Shabazz Delta Academy, field trips, and activities therein. I will facilitate and support my child's timely attendance and participation.

I agree not to hold the Rancocas Valley Alumnae Chapter of Delta Sigma Theta Sorority, Inc. or the Dr. Betty Shabazz Delta Academy and its members responsible and/or liable for any injuries or illnesses that my child may sustain while in attendance at the sessions of the Delta Academy. I also agree not to hold the above named organizations, or its members or appointees individually, liable for the loss or destruction of my child's property.

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**Parent/Guardian Signature and Date**





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**DR. BETTY SHABAZZ DELTA ACADEMY**

**CONSENT TO PHOTOGRAPH**

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I, \_\_\_\_\_, give permission for my

(Parent/Guardian)

daughter, \_\_\_\_\_, to be photographed and videotaped. My signature gives consent to the use of her likeness in any publication, educational material, advertising, news media, and World Wide Web materials that the Delta Academy may utilize and produce.

I understand and agree that such materials, including all negatives, positives, digital images, and prints shall become and remain the sole property of the Dr. Betty Shabazz Academy and I shall have no right or title to such items. I further understand and agree that these materials may be kept on file and used by the Dr. Betty Shabazz Academy for potential future use. I agree to release the Dr. Betty Shabazz Academy from any and all liability arising from or in connection with the taking, use, publication, or dissemination of such materials. Copies of these photos may be distributed to the parent upon request.

Parent /Guardian Signature: \_\_\_\_\_

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

Effective Date: September 1, 2008

Expiration Date: June 30, 2009



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**STUDENT HEALTH HISTORY RECORD**  
**2008-2009**

**To the parent/guardian:**

The health of the student is primarily the responsibility of her parent(s) or guardian(s). The Rancocas Valley Alumnae Chapter strongly recommends annual health examinations, dental check-ups and immunizations against preventable diseases. Our policy on health and safety implies a responsibility to the participants for their protection. It also implies the right of the organization to be assured, as much as possible, that the participants are physically able to take part in academy activities.

Student Name: _____  _____ DOB/Age: _____  _____ Address: _____  _____ City/State: _____  _____ Zip Code: _____  _____ Parent/Guardian Full Name: _____  _____ Phone Number: _____	Family Physician Name: _____  _____ Family Physician's Phone Number: _____  _____ Family Medical Insurance Carrier: _____  _____ Policy/Group Number: _____  _____								
<p><b>Part 1: Illnesses and Injuries</b> <i>(Circle those that apply and give appropriate detail in Part 5)</i></p> <p>Chronic or recurring illnesses:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 25%;">Ear Infections</td> <td style="width: 25%;">Bleeding/Clotting Disorders</td> <td style="width: 25%;">Hypertension</td> <td style="width: 25%;">Asthma</td> </tr> <tr> <td>Heart Defect/Disease</td> <td>Musculoskeletal Disorders</td> <td>Seizures</td> <td>Diabetes</td> </tr> </table> <p>Other: _____</p> <p>Were any complicating medical problems noted in the last health exam? If yes, please describe: _____</p> <p>_____</p>		Ear Infections	Bleeding/Clotting Disorders	Hypertension	Asthma	Heart Defect/Disease	Musculoskeletal Disorders	Seizures	Diabetes
Ear Infections	Bleeding/Clotting Disorders	Hypertension	Asthma						
Heart Defect/Disease	Musculoskeletal Disorders	Seizures	Diabetes						

<p><b>Part 2: Allergies</b> <i>(Check all that apply and specify and specify nature of any allergic reactions)</i></p> <p>Animals _____ Hay Fever _____</p> <p>Pollen _____ Food _____</p> <p>Drugs _____ Insect Stings _____</p> <p>Plants _____ Other (specify) _____</p>	<p><b>Part 3: Immunizations</b></p> <p>Are all of the student's immunizations up to date?</p> <p>Yes _____ No _____ <i>(If not, please explain in Part 5)</i></p> <p>Date of last:      DPT: _____</p> <p style="padding-left: 100px;">Tetanus: _____</p>
<p><b>Part 4: Other Health Conditions</b> <i>(Check all that apply)</i></p> <p>Bed Wetting _____ Emotional Disturbances _____</p> <p>Fainting _____ Hearing Impairment _____</p> <p>Constipation _____ Dental Appliances _____</p> <p>Nosebleeds _____ Sleep Disorders _____</p> <p>Motion Sickness _____ Special Dietary Needs _____</p> <p>Wears glasses/      Menstrual Cramps _____ contacts _____</p> <p>Sickle Cell Trait or      Other (specify) _____ Disease _____</p>	<p><b>Part 5: Notes</b> <i>(Please explain any items that are noted in previous sections. Indicate any information useful to the adult in charge in relation to any of these health conditions. Also indicate any activities to be restricted.)</i></p>       
<p><b>Part 6: Medication Directions</b> <i>(Please give detailed directions for any medications to be given to your child. Include dosage and times.)</i></p>	<p>I know of no reason(s) other than the information on this form, why my daughter should not participate in academy activities.</p> <p><b>Parent/Guardian Signature:</b></p> <p>_____</p>

**PARENT AUTHORIZATION FOR MEDICAL EMERGENCY TREATMENT**

*(Sign **ONE** section only)*

<p>In case of medical emergency, I understand every effort will be made to contact parents or guardian of the child. In the event I cannot be reached, I hereby give permission to the physician selected by authorized representative(s) of Prince George's County Alumnae Chapter to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my child.</p> <p>Student's Name: _____</p> <p>Parent/Guardian Signature: _____</p> <p>Date: _____</p>	<p style="text-align: center;"><b><i>(Sign only if you decline to sign release at left)</i></b></p> <p>I have been offered the opportunity to authorize emergency medical care as set forth (on left) and decline to so authorize said emergency medical care without my approval and accept such complications as may occur should said medical care be needed and unavailable due to my being unavailable to provide the same.</p> <p>Student's Name: _____</p> <p>Parent/Guardian Signature: _____</p> <p>Date: _____</p>
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