DELTA SIGMA THETA SORORITY, INCORPORATED

RANCOCAS VALLEY ALUMNAE CHAPTER

DR. BETTY SHABAZZ DELTA ACADEMY

APPLICATION FORM

2009-2010

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)*:

____

____

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

____

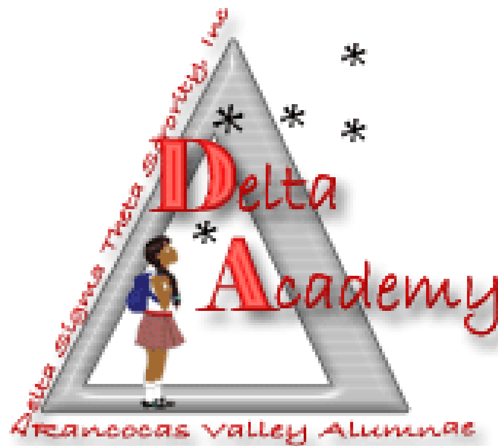
____

Which school subject do you need help with most? ______Science _____Math

What new subject would you like to learn about? _______________________________________

____

Student Signature and Date



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RANCOCAS VALLEY ALUMNAE CHAPTER

DR. BETTY SHABAZZ DELTA ACADEMY

PARENT CONSENT FORM
2009-2010

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? _____________________________

____

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

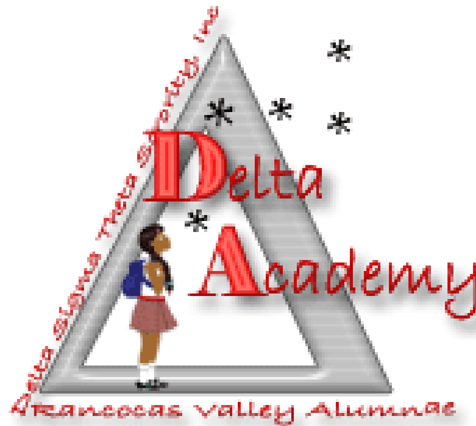
____

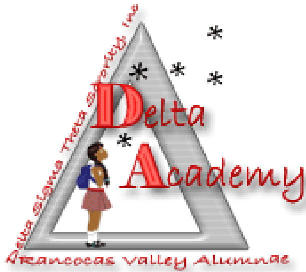
By my signature below, I hereby verify that the above information is accurate. My signature grants permission for my child to participate in the Dr. Betty Shabazz Delta Academy, field trips, and activities therein. I will facilitate and support my child's timely attendance and participation.

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.

____

Parent/Guardian Signature and Date





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CONSENT TO PHOTOGRAPH

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, 2009

Expiration Date: June 30, 2010

DELTA SIGMA THETA SORORITY, INCORPORATED

RANCOCAS VALLEY ALUMNAE CHAPTER

DR. BETTY SHABAZZ DELTA ACADEMY

STUDENT HEALTH HISTORY RECORD

2009-2010

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: ______________________	Family Physician Name: ______________________
DOB/Age: ______________________	Family Physician's Phone Number: ______________________
Address: ______________________	Family Medical Insurance Carrier: ______________________
City/State: ______________________	Policy/Group Number: ______________________
Zip Code: ______________	
Parent/Guardian Full Name: ______________________	
Phone Number:______________________	

Part 1: Illnesses and Injuries *(Circle those that apply and give appropriate detail in Part 5)*

Chronic or recurring Illnesses:

Ear Infections	Bleeding/Clotting Disorders	Hypertension	Asthma
Heart Defect/Disease	Musculoskeletal Disorders	Seizures	Diabetes

Other: ____

Were any complicating medical problems noted in the last health exam? If yes, please describe: _________

____

Part 2: Allergies *(Check all that apply and specify and specify nature of any allergic reactions)*

Animals________ Hay Fever________

Pollen________ Food________

Drugs________ Insect Stings________

Plants________ Other (specify) ________

Part 3: Immunizations

Are all of the student's immunizations up to date?

Yes________ No________ (*If not, please explain in Part 5*)

Date of last: DPT:_________________

Tetanus:______________

Part 4: Other Health Conditions *(Check all that apply)*

Bed Wetting_______ Emotional Disturbances______

Fainting________ Hearing Impairment________

Constipation______ Dental Appliances________

Nosebleeds______ Sleep Disorders________

Motion Sickness_____ Special Dietary Needs______

Wears glasses/ contacts________ Menstrual Cramps________

Sickle Cell Trait or Disease________ Other (specify) ________

Part 5: Notes (*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.*)

Part 6: Medication Directions *(Please give detailed directions for any medications to be given to your child. Include dosage and times.)*

I know of no reason(s) other than the information on this form, why my daughter should not participate in academy activities.

Parent/Guardian Signature:

____

PARENT AUTHORIZATION FOR MEDICAL EMERGENCY TREATMENT

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

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.

Student's Name: ____

Parent/Guardian Signature: ________________________________

Date: _____________________________

(Sign only if you decline to sign release at left)

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.

Student's Name: ____

Parent/Guardian Signature: ________________________________

Date: _____________________________