

Dr. Betty Shabazz Delta Academy



**Catching the Dreams of Tomorrow,
Preparing Young Women For the 21st Century**

DR. BETTY SHABAZZ DELTA ACADEMY

August 30, 2010

Dear Parent/Guardian:

The Federal City Alumnae Chapter of Delta Sigma Theta Sorority, Inc. invites your daughter to participate in its Dr. Betty Shabazz Delta Academy which is one of the Sorority's national initiatives for youth. The Delta Academy is named for the outstanding and accomplished widow of Malcolm X, in recognition of her contributions as an outstanding educator and role model for young women.

The symbol for the Delta Academy is the Dream Catcher. A Dream Catcher, from Native American culture, is believed to possess the power to capture bad dreams, entangling them in the Catcher's web, thus allowing only good dreams to pass through and into the person's being. *The Delta Academy is a dream catcher!* It helps its members recognize, receive and plan for reaching their dreams and goals, as well as making their dreams a part of their being and a foundation for their future. The goals of the Delta Academy are achieved through challenging and fun activities, field trips, and other special incentives. A particular emphasis is placed on African American history, literacy, self-esteem, non-traditional careers, service learning, and leadership development.

The "Delta Academy" specially designed for young ladies 11 - 14 years of age, will provide scholarship, service learning activities, and sisterhood enrichment opportunities for young ladies to prepare them for the 21st century and beyond. The "Delta Academy" is seeking young ladies who are: interested in developing their leadership skills, interested in computers and technology, interested in learning new things and who want to do all of these things in a fun environment.

If you would like for your daughter to become a part of this rewarding and exciting experience, please complete the attached application package, including the student application, parent consent form and health history form. The packet should be submitted to the address below by Wednesday, September 15, 2010. If you have questions, please feel free to contact Committee Co-Chairs, Sharon Williams Jackson at 202-316-5753 or Stephanie Minor-Harper at 240-350-6220.

Please mail completed application packets by September 15, 2010 to:

**The Dr. Betty Shabazz Delta Academy
Delta Sigma Theta Sorority, Inc.
P.O. Box 1605
Washington, D.C. 20013**

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**DR. BETTY SHABAZZ DELTA ACADEMY
STUDENT APPLICATION FORM
2010-2011**

Student Name: _____

DOB: _____ Age: _____ Current Grade: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Numbers: (Home) _____; (Cell): _____

E-mail address: _____

School Name: *(Please give FULL name)*

City: _____ State: _____ Zip Code: _____

Teacher Name: _____

Extra-Curricular Activities/Hobbies: _____

Have you previously participated in the Dr. Betty Shabazz Delta Academy? If yes when?

Why are you interested in participating in the Dr. Betty Shabazz Delta Academy?
What workshops/activities would you like to see included in the program?

Student Signature and Date:

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Student Commitment and Pledge Contract

I will strive for discipline and dedication in all that I do.

I will strive to do my best in all that I do.

I will respect others' space, opinion, and time.

I will listen to what others have to say.

I will respect others' property.

I will ask for help and help others when needed.

I will be on time for sessions and activities.

I will take responsibility for my actions.

I will not strike out (physically/verbally) in anger.

I will be willing to open my mind to new ideas.

Student Signature _____ **Date** _____

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PARENTAL CONSENT and WAIVER FORM
2010-2011

Parent/Guardian Name: _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Numbers: (Home) _____; (Work) _____; (Cell) _____

E-Mail Address: _____

How did you learn about the Delta Academy? _____

By my signature below, I grant permission for my child to participate in the Dr. Betty Shabazz Delta Academy workshops, field trips, and other educational or cultural activities sponsored by the Federal City Alumnae Chapter of Delta Sigma Theta Sorority, Inc. for the period October 1, 2010 thru June 30, 2011.

I understand that the program participants are females between 11 and 14 years of age; who are residents of the D.C. Metropolitan Area; and who are currently enrolled in a public, private, or charter school in the D.C. Metropolitan Area. I also understand that I am expected to facilitate and support my child's attendance and participation.

Further, I understand reasonable efforts will be made to supervise my child. I and my child understand that certain conduct (for example, unacceptable sexual conduct, unacceptable dress, violent speech or conduct, and the use of controlled substances or alcohol) will not be tolerated in the program and that the commission of any of these acts will result in immediate dismissal from the program. I understand that in the event that

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one of these acts occurs, the Dr. Betty Shabazz Delta Academy will contact via the numbers provided either the parent or emergency contact person on file. I agree that when I or the emergency contact person is called, the emergency contact person or I will immediately come and pick my child up from the session and/or activity.

Further, I agree not to hold the Federal City 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.

Consent to Photograph

I, _____, hereby authorize the Dr. Betty Shabazz Academy to photograph or film my daughter, _____ and consent to the use of her likeness in any and all publications, educational materials, research, advertising, news media, and World Wide Web materials.

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 purposes and further 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

Dr. Betty Shabazz Delta Academy



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Health History/Medical Consent Form

2010-2011

Student Name: _____

Date of Birth: _____ Age: _____ Current Grade: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Parent/Guardian Full Name: _____

Phone Numbers: (Home) _____ (Work) _____ (Cell) _____

E-mail Address: _____

Family Medical Insurance Carrier: _____

Policy/Group Number: _____

Family Physician: _____

Physician Phone Numbers: (Day) _____ (Evening) _____

Emergency Contact Information if parent(s) cannot be reached in event of emergency:

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

Is the student up to date on her immunizations? Yes _____ No _____

If no, please explain in box below.

Is the student on medication? Yes _____ No _____

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If yes, please list in box below and provide information on dosage to take and times when it should be taken.

Does your student have any allergies? Yes _____ No _____

If yes, please explain in box below.

Does your student have any special dietary needs/restrictions? Yes _____ No _____

If yes, please explain in box below.

In the box below, please provide any specific information you think would be helpful, including physical, psychiatric or behavioral problems.

Parent Permission Statement

The health history provided is correct as far as I know, and my daughter has my permission to engage in all activities except as noted. If she appears ill, I will not send her.

Emergency Authorization: In the event I, or my designated emergency contact person, cannot be reached in an emergency, I hereby grant permission to The Federal City Alumnae Chapter to secure proper treatment for my child.

Student Name: _____

Parent/Guardian Name (*please print*) _____

Parent/Guardian Signature: _____ Date: _____