St. Mary's Health Professions Academy
Student Application

Tenth and eleventh grade students in tri-state area who are interested in a health care career will be considered for the St. Mary's Health Professions Academy. The Academy will be held on **June 5th and 6th** at the St. Mary's Center for Education. **Only complete applications will be accepted. Applications must be received by May 1, 2018.**

Application Requirements Include:

- *You must have at least a 2.5 or greater **current overall grade average***
- *You must be a current high school student attending **10th or 11th grade***

I. STUDENT INFORMATION

please type or print all responses legibly in ink

Last Name | First Name | Middle Initial | Nickname

Birth Date (Month/Day/Year) | Home Phone | Cell Phone | Email Address

Mailing Address | PO Box/Rural Route

City | State | County | Zip Code

T-Shirt Adult Size: (*please circle one*)
XS (4/6)
S (6/7)
M (8-10)
L (12/14)
XL (16)
2XL
3 XL

Gender:
Male
Female

Race: (*circle one or more*)
Caucasian
American Indian/Alaskan Native
African American
Asian
Hispanic (non-Caucasian)
Pacific Islander
Mixed Race

Medical Problems and/or Medications:

How did you hear about St. Mary's Health Professions Academy?

II. SCHOOL INFORMATION

Name of School Currently Attending | Current Grade in School

School Address | City | State

County | Zip Code | Phone (Including Area Code)

Current overall grade average (Must be at least 2.5 GPA)

III. STUDENT AND PARENT SIGNATURES

I certify that the information contained in this completed application is accurate. I understand that falsification of any information on this application may result in my being disqualified from the application process and/or the St. Mary's Health Professions Academy. If I am selected for the Academy and choose to participate, I agree to abide by all Academy rules and guidelines and participate in all of the scheduled activities.

Student Signature **Date**

I have read the application and certify that the information is accurate. I give my permission for my child to apply and participate in the St. Mary's Health Professions Academy. If my child is accepted and participates, I agree to support him/her throughout the program and will willingly respond as requested to the St. Mary's Health Professions Academy surveys regarding my child and his/her participation. I hereby agree that all participating entities will not be held responsible for any injury or accident that might occur through participation in the St. Mary's Health Professions Academy; in addition, any medical expenses incurred as a result of such injury or accident will be my personal responsibility.

Parent/Guardian Signature **Date**

In case of medical emergency, staff must be able to contact a parent/guardian or other emergency contact authorized to approve medical treatment for the student. Please provide current, accurate information and assure that you and/or a back-up contact are always available while the student is participating in Academy activities.

Parent/Guardian Name (print)

Address

Home Phone Cell Phone Work Phone

Back-Up Contact Name (print)

Relationship to Student

Home Phone Cell Phone Work Phone

Please Return Application to:

Dr. Joey Trader, Ed.D., MSN, RN, CNE
Vice President Schools of Nursing and Health Professions
Director School of Nursing
St. Mary's Center for Education
2900 First Avenue
Huntington, WV 25702
Office: 304-526-1416
Fax: 304-399-1981

For Questions and Concerns:

Paula Cremeans
Administrative Secretary
St. Mary's Center for Education
2900 First Avenue
Huntington, WV 25702
Office: 304-526-1426

Completed Application Must Be Returned by May 1, 2018

St. Mary's Health Professions Academy
Health Assessment Form

Instructions to Parent/Guardian: *Please fill out your child's medical form and include it with the other forms to be returned to the Academy.*

Student's Name: _____ DOB: _____

HEALTH ASSESSMENT:

Complete each line	**Yes**	**No**	**Comments**
Vision / Wears Corrective Lenses			
Hearing / Wears Hearing Aid			
Skin Disorder			
Special Nutritional Requirements			
Neurological Disorders (such as Epilepsy)			
Spinal Disorder			
Allergies (Medication, Food, Latex or Environmental)			
Digestive Disorder			
Muscular Disorder			
Asthma			
Heart Problems			
Tobacco Use			
Pregnant			

Chronic illness that may require medication or special accommodations?_____
If ***yes***, please explain:_____

_____

Parent Signature: _____ Date: _____

ST. MARY'S
CENTER FOR EDUCATION
School of Nursing • School of Radiology • School of Respiratory Care

Consent to Photograph

Name: *(please print)*

_____

Last First Middle

I hereby give consent to St. Mary's Medical Center to take moving and/or still photographs and/or sound/video recordings for any and all educational and/or marketing purposes that the hospital may deem proper of (check appropriate person):

□ Son □ Daughter
□ Other individual for whom I am authorized to provide consent

Made on (date pictures taken): June 5th and June 6th, 2018

Used for: St. Mary's Center for Education

I understand that these photographs and/or sound/video recordings will be used on behalf of St. Mary's Medical Center for the above stated purposes. I further relinquish all right, title and interest in said moving and/or still photographs and sound/video recordings.

I also state that I have signed this form **PRIOR** to the taking of any photographs and/or sound/video recordings.

Participant's Signature: _____ Date: _____

Parent's Signature: _____