

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 6th and 7th** at the St. Mary's Center for Education. **Only complete applications will be accepted. Applications must be received by May 1, 2017.**

Application Requirements Include:

- *You must have at least an 80% or 3.0 current overall grade average*
- *You must be a current high school student attending 10th or 11th grade*
- *You must submit a brief essay (1 page limit) that explains your personal interest in the health care profession and why attending the St. Mary's Health Professions Academy is important to you. Your essay must be submitted with this application.*

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:

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 80% or 3.0 GPA) |

III. INFORMATION TO BE COMPLETED BY SCHOOL COUNSELOR OR TEACHER

School Counselor/Teacher Name (print) Title Phone Number

I certify that the student applicant has a current overall grade average of _____ %. (Must be at least 80% or 3.0 GPA)

School Counselor/Teacher Signature Date

IV. STUDENT AND PARENT SIGNATURES

I certify that the information contained in this completed application is accurate. I certify that I wrote the essay I am submitting with this application. 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)

Back-Up Contact Name (print)

Address

Relationship to Student

Home Phone Cell Phone Work Phone

Home Phone Cell Phone Work Phone

Please Return Application to:

Shelia M. Kyle, EdD, MSN, RN
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, 2017

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:

| <i>Complete each line</i> | 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: _____



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 6th and June 7th, 2017

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: _____

St. Mary's Medical Center for Education
2900 First Ave – Huntington, WV – 25702 (304) 526-1426