

Health Careers Program

HCA PARTICIPANT ENROLLMENT FORM

Your 8 digit Participant Identification number is made up of: 2 digits of your birth month (01-12), 2 digits of your birth day (01- 31), and the last four digits of your Social Security Number. This identifier protects your personal information in our database and allows us to provide you credit for this course.

Example: The Participant ID for someone born 11/21/1989 with the SSN 123-45-6666 would be: 11/21/6666

Participant ID ____ / ____ / ____

First Name: _____

Middle Name: _____

Last Name: _____

Mailing Address: _____

City: _____

State: _____

Zip: _____

County: _____

This is my permanent address? Yes No

Home Phone: _____

Student Cell Phone: _____

Email: _____

It is OK for AHEC to contact me at the above addresses or phone numbers.

Date of Birth: ____/____/____

Your Primary Language?

- English
 Other

Ethnicity?

- Hispanic/Latino
 Other

Race (check as many as apply)

- American Indian or Alaskan Native
 Asian
 Black or African American
 Native Hawaiian or Other Pacific Islander
 White

Gender:

- Male Female

Neighborhood Type:

- Rural Suburban Urban

Anticipated High School Grad Date: ____/____/____

Grade Level: Freshman Sophomore Junior Senior

High School: _____

High School Mailing Address:

City: _____

State: _____

Zip: _____

Do you receive a free or reduced price lunch? Yes No

Guidance Counselor's Name: _____

Career Interest: _____

My signature authorizes South Carolina AHEC and the regional AHEC Centers (Lowcountry AHEC, Mid-Carolina AHEC, Pee Dee AHEC, and Upstate AHEC) to release information from this application and letters of reference as they may deem appropriate. Additionally, I grant South Carolina AHEC and the regional AHEC Centers permission to use my/my child's personally identifiable information for the purposes of federal, state or grant related tracking to report programmatic outcomes. I also give my explicit permission for the South Carolina AHEC and the regional AHEC Centers to use my/my child's image and statements. Uses include, but are not limited to: photography, videotape, organizational web site, or print media.

Parent/Guardian Signature: _____ Date: _____

Name: (Please Print): _____ Email: _____



Health Careers Academy Regulations & Guidelines

The following is an outline of academy regulations and guidelines that will assist us in maintaining an environment conducive to learning, enjoyment and safety.

- Students must arrive at all academy-sponsored activities prepared with the necessary supplies and attitude.
- Students should be punctual for all academy-sponsored activities.
- Students are required to participate in group activities, independent study activities and mentoring.
- Student/parent must give permission for the Health Careers Program Coordinator to access the student academic record and meet with the student's school counselor if necessary.
- Students must dress appropriately at all times. Example, school dress code will apply unless otherwise stated.
- Students will listen attentively and be respectful of others while they are speaking and not interrupt.
- Students will complete all assignments
- Students will support and encourage their peers and other academy members.
- Parents are expected to get the student to meetings on time as well as pick the student up on time.
- Parents are expected to encourage and participate in an open line of communication between the student, parent, and program coordinators.
- Parents are expected to actively participate in program activities as needed.
- Students must pay an annual \$25 membership fee each school year. This fee will help to partially off-set the cost of meals and supplies for HCA members. Fees may be incurred for special projects (ex: CPR cards, field trips, etc.)

Student Signature _____

Date _____

Parent Signature _____

Date _____



Health Careers Academy
Affidavit of Waiver

I, _____, am aware and agree that South Carolina AHEC/Lowcountry AHEC, hereafter called AHEC, its agents, officers, employees and assigns are not, nor will they be held personally or officially liable for any and all damages resulting from any and all incidents, accidents, injuries, or claims which may arise out of my (my child's-if a minor) participation in the any AHEC sponsored activity. I understand that I am (my child is) participating in this program and its program activities totally at my (my child's) own risk. AHEC will not, in any circumstances, be held liable for any accidents, incidents, injuries or claims which may arise out of such program activities, including but not limited to field trips, outings, tours, transportation or any other activities.

WHEREOF, I waive any and all rights that may arise to hold liable by any cause of action of AHEC, its agents, officers, employees, and assigns in their official and personal capacity.

Executed on this, the _____ day of _____, 20_____

Signature of Applicant

Signature of Parent/Guardian if a minor



Health Careers Academy Emergency Information Form

Student's Name: _____

Home Address: _____

City: _____ State : _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

In case of an emergency, please contact the following: (List two people).

Name: _____ Relationship: _____

Home Address: _____

City: _____ State : _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Name: _____ Relationship: _____

Home Address: _____

City: _____ State : _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____



Health Careers Academy
Health Information Form

Student's Name: _____

Past/Present Health History (list all pertinent information and medications).

Food and/or Drug Sensitivities/Allergies:

Date of last tetanus shot: _____

Health Insurance Company and address: _____

Policy Holder: _____

Policy Number: _____

If necessary, I agree (allow my child) to be treated by a licensed medical professional while participating in the Health Careers Academy, and to assume all costs related to such treatment. (Enclose a photocopy of insurance card).

Parental Signature: _____ Date: _____



Health Careers Academy HIPAA Confidentiality Statement

I, _____, promise to be respectful of the issues that are discussed in the Health Careers Academy. I will not repeat, discuss, share or communicate any "private information that is shared by my peers or HCP Coordinator that could be misinterpreted or considered "sensitive" in any way".

Student's Signature:

Date:

"When it comes to patient information, breaches of confidentiality carry serious consequences."



Health Careers Academy
Statement of Waiver and Release

My signature authorizes the South Carolina AHEC to release information from this application and letters of reference as they may deem appropriate. Additionally, I grant the South Carolina AHEC permission to use my personal identifiable information for the purposes of federal, state and grant tracking and reporting. I also give my explicit permission for the South Carolina AHEC and its regional AHEC sites and other sponsoring agencies to use my image. Uses include, but are not limited to: photography, videotape, organizational web site, or print media.

Executed on this, the _____ day of _____, 20_____

Signature of Applicant

Signature of Parent/Guardian if a minor



Health Careers Academy
Photo Release Form

I understand my photograph may be taken. I hereby release my comments and photographs for publicity purposes only. I understand that my image may be released to local, regional, and/or statewide publications in an effort to gain recognition for the program. I also recognize that my statements and photographs may be used in a variety of AHEC marketing materials produced for program recruitment purposes. I also understand that I will not be compensated for the publication of my statements or photographs.

My signature below denotes that I have read the above statement and fully agree with its contents.

Signature _____ Date _____

Parent's Signature _____ Date _____
(Parent's signature required if under 18 years of age)



Health Careers Academy
Parental Consent form to School Counselor

I, _____, the parent of _____, give
Name of Parent Name of Student
permission to Katura Williams, to receive information from the school
Health Careers Coordinator
in the form of academic grades, disciplinary records, extracurricular activities, etc.,
for the duration of his/her participation and enrollment in the Lowcountry AHEC
Health Careers Academy. Please contact: _____ if you
Name of Parent
have any questions, comments or concerns.

Parental Signature Date

Counselor's Signature Work Number Date