Health Careers Program
Health Careers Academy (HCA)
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.
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:_____ **MI:**_____ **Last Name:**_____

Permanent Mailing Address:_____

City:_____ _____ **State:**_____ **Zip Code:**_____

County:_____ **Date of Birth:** _____/_____/_____

Home Phone:_____ **Student Cell Phone:**_____

Email:_____

Can AHEC contact you at the above address, phone numbers, or email address? ___Yes ___No

Your Primary Language? English____ Other____

Gender:
Female ___ Male ___Decline to Self-Identify

Race (check all that apply):
___American Indian or Alaskan Native
___Black or African American
___Native Hawaiian or Other Pacific Islander
___White

Ethnicity: ___Hispanic ___Not Hispanic or Latino

Neighborhood Type:
___Rural ___Suburban ___Urban

Middle & High School Students:
School:_____
City:_____ State:____ County:_____
Grade Level: ☐8 ☐9 ☐10 ☐11 ☐12 Grad Year:_____
Career Interest:_____
Guidance Counselor's Name:_____
Do you receive free or reduced lunch? ___Yes ___No

College Students Only:
College:_____
City:_____ State:____ County:_____
Classification:_____ Grad Date:_____
Career Interest:_____
High School:_____
City:_____ State:_____ Grad Year:_____

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 regioal AHEC Centers to use my/my child's image and statements. Uses include, but are not limited to: photography, videotape, organizational website, or print media.

Student/Parent or Guardian (If under 18) Signature:_____ **Date:**_____

Parent or Guardian Name:_____ **Email:**_____
(Please Print)

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 attend 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, mentoring and complete all service-learning hours.
- 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 during meetings 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 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.

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 Jalacy Green , to receive information from the school
Health Careers Program 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