

**Student Application**

LOCATION:

DATE:

APPLICATION DEADLINE:

PLEASE COMPLETE APPLICATION AND MAIL TO:

FOR MORE INFORMATION:

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| **Personal Information** | |
| Student Name: | |
| Home Address:  City/State/Zip: | |
| Phone Number: | |
| E-mail Address: |  |
| Shirt Size (circle one): ADULT XS S M L XL 2XL 3XL 4XL 5XL | |
| Date of Birth (mm/dd/yy): | |
| Ethnicity (circle): Hispanic Non-Hispanic | |
| Race (circle): American Indian/Alaskan Native Asian Black/African   Caucasian/White Native Hawaiian/Pacific Islander | |
| Gender (circle one): Male Female | |
| List any food allergies or requirements that scrubs camp should be aware of: | |

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| **Educational Information** |
| Name of school presently attending: |
| City: |
| Current grade in school (circle one): 5th 6th 7th 8th 9th 10th 11th 12th |
| Student ID# |

\*Student ID# are required for tracking purposes and are needed for the Scrubs Camp Roster. The school will have a student ID#.

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| **Parental Information** |
| Name of Parent/Guardian: |
| Phone Number: |
| E-mail Address: |
| Parent/Guardian Signature: |

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| **Waiver** | |
| In consideration of the insert site/lead applicant name acceptance of my participation in the R-COOL Health Scrubs Camp, I waive any and all claims for myself and my heirs that I may have against the insert site/lead applicant name, its employees, contractors, sponsors, officials, and volunteers, for any and all injury or illness which may directly or indirectly result from my participation in this program. | |
| Parent/Guardian Signature: | Date: |
| Student (if over 18) Signature: | Date: |

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| **Photo/Video & Evaluation Waiver** | |
| I hereby grant permission for the coordinators and sponsors of the R-COOL-Health Scrubs Camp to take, edit, and use photos/videos for publicity, news, and advertising. I understand that the photos/videos may be used only for educational and public information purposes.  \_\_\_ I grant permission \_\_\_ I do not grant permission  I authorize the Center for Rural Health and the ND AHEC to maintain and reference the application and registration information periodically to evaluate the effectiveness of the Scrubs Academy. Students participating in the Scrubs Camp may be contacted in the future for evaluation purposes.  \_\_\_ I authorize \_\_\_ I do not authorize | |
| Parent/Guardian Signature: | Date: |

*To be completed by a school counselor, teacher, or administrator*

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| **Why do you recommend this student be accepted into the R-COOL Health Scrubs Camp?** |
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| Signature: Position: |