Marshall University Joan C. Edwards School of Medicine
Health Care Pipeline Initiative Program

SCHOOL OF PHARMACY

Student Information (To Be Completed by STUDENT)

Student Last Name: _____ First Name: _____ Middle: _____

High School Attending:_____ T-Shirt Size: _____

Student's Cell Phone Number: _____ Student's Email Address: _____

Grade level: _____Freshman _____Sophomore _____Junior _____Senior Graduation Date:_____/_____/_____

List all math classes you have taken and grade received: _____

_____

What interests you the most Math, Science, Technology, Engineering or other subject area? _____

Why?_____

_____

Opinions and thoughts. Please answer on a separate document if needed.

1. Why should you be selected to attend Summer Health Care Pipeline Initiative? _____

_____

_____

_____

_____

2. What is your favorite subject and why? _____

_____

_____

3. What is your least favorite subject and why? _____

_____

_____

4. If you could learn anything what would it be and why? _____

_____

_____

_____

5. Do you plan on attending College? If so, why do you feel that it is important? _____

_____

_____

_____

_____

Family & Income Information (To Be Completed by PARENT/GAURDIAN)

Student Last Name: _____ First Name: _____ Middle: _____

MOTHER/FEMALE GUARDIAN

Name: _____ Home/cell phone number: _____ _____

Address: _____ City: _____ State: _____ Zip: _____

Employer _____ Occupation_____

Please check the highest level of education completed: ❍ High school ❍ Some college ❍ Four-year college degree

FATHER/MALE GUARDIAN

Name: _____ Home/cell phone number: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer _____ Occupation_____

Please check the highest level of education completed: ❍ High school ❍ Some college ❍ Four-year college degree

The financial information requested below is required by AEOP/UNITE to determine your son/daughter's eligibility for the HCPI Program. Taxable income is located on the second page of your 1040 tax return.

Additional Information about Student

Mark all items [yes] or [no] - Provide detail if answer is [yes]

Disabled	❍ yes ❍ no	Receives special education services	❍ yes ❍ no
English as a Second Langue	❍ yes ❍ no	Attends rural or frontier school	❍ yes ❍ no
First Generation	❍ yes ❍ no	Qualifies for free or reduced lunch	❍ yes ❍ no

List details to items marked [yes]; _____

_____

I certify that the above information is true to the best of my knowledge.

➲

Parent/Guardian Signature: _____ Date: _____

Marshall University Joan C. Edwards School of Medicine Health Care Pipeline Initiative Program

Medical Authorization Form (To Be Completed by PARENT/GAURDIAN)

Throughout the year, we take our students on a variety of field trips. It is necessary that we have an accurate medical history in the event that emergency treatment is required. All information is confidential. Any student without a completed and signed Medical Authorization Form will not be allowed to participate in field trips.

Student Last Name:	**First Name:**		**Middle:**
Social Security #:	**Date of Birth:**		
Mailing Address: Street and Apt. No.			
City:	**State: WV**	**Zip:**	
Home Phone Number:	**Parent Cell Phone Number:**		
Emergency Contact Name and Phone # if unable to contact parent:			
Grand parent or closest relative name and phone:			

Medical Insurance Information

Policy Holder's Name: _____ Policy#: _____

Insurance Company Name: _____ Group #: _____

Physician's Name: _____ Physician Phone #: _____

Medical History of Student

Mark all items [yes] or [no] - Provide detail if answer is [yes]

Diabetes	❍ yes	❍ no	Drug Allergy	❍ yes	❍ no
Food Allergy	❍ yes	❍ no	Insect Bite Allergy	❍ yes	❍ no
Hearing Defects	❍ yes	❍ no	Convulsions/Epilepsy	❍ yes	❍ no
Asthma	❍ yes	❍ no	Currently taking medication	❍ yes	❍ no
Currently Under doctor's care	❍ yes	❍ no	Physical restrictions	❍ yes	❍ no

Date of last physical _____ Date of last tetanus shot _____

If currently taking medication indicate type and reason: _____

List details to items marked [yes]; _____

_____

I understand that should a health emergency arise; I will be notified as soon as possible and medical treatment as deemed necessary by competent medical personnel is authorized. Other than medical emergency, I authorize the University to examine and treat my child in the same way that Marshall University students are treated with notification of parents being dependent on the judgment of the physician. In addition, I agree to indemnify and save and hold harmless Marshall University, its officers, agents and employees from and against any and all claims and liabilities which may arise out of or result from or be in any way connected directly or indirectly while participating in the program.

➲ **Student Signature** _____ **Date** _____

➲ **Parent/Guardian Signature** _____ **Date** _____

Marshall University Joan C. Edwards School of Medicine
2018 Health Care Pipeline Initiative Program

MARSHALL
SCHOOL OF PHARMACY

Reference Form

Student Last Name: _____ Student First Name: _____

In what capacity have you known the applicant? _____ How long have you known the applicant? _____Years

Please check (√) the following questions indicating how you feel the applicant would meet the criteria as an HCPI 2018 participant. Then, indicate whether this is your "Opinion" from general knowledge of the applicant or first-hand "Knowledge" if you have actually worked with the applicant in a situation where he/she displayed these specific characteristics. E - Excellent; G - Good; F - Fair; P – Poor

	E	G	F	P	Opinion	Knowledge
Working with Others						
A. Peers						
B. Adults						
C. Fairness with others						
D. See things from other viewpoints						
Leadership Skills						
A. Guides others						
B. Plans and organizes						
C. Manages time efficiently						
D. Delegates responsibility						
E. Motivates others						
F. Has initiative to do things without being told						
Responsibility						
A. Will obey rules						
B. Maturity in handling problems						
C. Sound judgment						
D. Observe and follow through with all duties, assignments, and responsibilities						
Personal Skill and Concept						
A. Self-confidence						
B. Enthusiastic						
C. Good role model						
D. Positive attitude						
E. Restrain from alcohol/drug use						
F. Restrain from use of profanity						

Are you aware of any facts demonstrating that the applicant should not be considered by as a Health Care Pipeline Initiative participant?

_____No | _____ Yes, explain. _____

Would you recommend this teen to serve as a Health Care Pipeline Initiative participant? _____ Yes _____ No

Do you have any additional comments concerning the suitability of this applicant as a 2018 Health Care Pipeline Initiative participant? _____

_____

Reference Name:_____ Reference Signature:_____

Reference Email Address: _____

Position/Title/Unit/Address: _____

Cell Phone Number: _____ Work Phone Number: _____