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

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 AEO/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

English as a Second Language  ○ yes  ○ no

Receives special education services  ○ 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: ____________________________


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.

<table>
<thead>
<tr>
<th>Student Last Name:</th>
<th>First Name:</th>
<th>Middle:</th>
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<table>
<thead>
<tr>
<th>Social Security #:</th>
<th>Date of Birth:</th>
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Mailing Address: Street and Apt. No.

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<tr>
<th>City:</th>
<th>State: WV</th>
<th>Zip:</th>
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<table>
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<tr>
<th>Home Phone Number:</th>
<th>Parent Cell Phone Number:</th>
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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
- Food Allergy
- Hearing Defects
- Asthma
- Currently Under doctor’s care

Yes | No
--- | ---

Drug Allergy
Insect Bite Allergy
Convulsions/Epilepsy
Currently taking medication
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 ________________
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

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