Saint Luke's College of Health Sciences

PATHWAY TO HEALTH AND SCIENCE EDUCATION PROGRAM

PERSONAL INFORMATION (PLEASE TYPE OR PRINT CLEARLY)

1. NAME:_____
   FIRST NAME MIDDLE NAME LAST NAME

   DATE OF BIRTH:_____ AGE:_____

   PLACE OF BIRTH: _____

2. LEGAL RESIDENCE:_____
   STREET/APARTMENT/PO BOX

   _____
   CITY STATE ZIP CODE

   AREA CODE/TELEPHONE NUMBER_____ CELL PHONE NUMBER_____

3. E-MAIL ADDRESS (MOST FREQUENTLY USED AND CHECKED)_____

FAMILY AND SCHOOL INFORMATION

GENDER: ☐ MALE ☐ FEMALE

ETHNICITY: ☐BLACK/AFRICAN AMERICAN ☐CAUCASIAN ☐NATIVE AMERICAN/ALASKAN ☐HISPANIC/LATINO

☐ASIAN ☐NATIVE HAWAIIAN/PACIFIC ISLANDER OTHER (SPECIFY) _____

FAMILY SIZE:_____

FATHER:

NAME: _____ OCCUPATION: _____

EDUCATION: ☐LESS THAN/PARTIAL HIGH SCHOOL ☐HIGH SCHOOL GRADUATE ☐SOME COLLEGE ☐ASSOCIATES DEGREE

☐BA/BS DEGREE ☐GRADUATE SCHOOL ☐PROFESSIONAL SCHOOL (SPECIFY)_____

MOTHER:

NAME: _____ OCCUPATION: _____

EDUCATION: ☐LESS THAN/PARTIAL HIGH SCHOOL ☐HIGH SCHOOL GRADUATE ☐SOME COLLEGE ☐ASSOCIATES DEGREE

☐BA/BS DEGREE ☐GRADUATE SCHOOL ☐PROFESSIONAL SCHOOL (SPECIFY)_____

INDICATE SCHOOL CURRENTLY ATTENDING AND PRESENT GRADE:_____

☐HIGH SCHOOL FRESHMAN ☐HIGH SCHOOL SOPHOMORE ☐ HIGH SCHOOL JUNIOR

☐ HIGH SCHOOL SENIOR

UNDERGRADUATE GPA: _____ SCIENCE GPA: _____

LIST HONORS RECEIVED (INCLUDING HONOR SOCIETIES)

LIST EXTRACURRICULAR AND COMMUNITY ACTIVITIES

LIST SCIENCE AND MATHEMATICS COURSES YOU EXPECT TO COMPLETE THIS SCHOOL YEAR:

PERMISSION FOR STUDENT TO PARTICIPATE IN PATHWAY TO HEALTH AND SCIENCE EDUCATION PROGRAM

THE PROGRAM IS OPEN TO HIGH SCHOOL STUDENTS FROM 9TH TO 12TH GRADE, AND THERE IS NO COST FOR STUDENTS TO PARTICIPATE IN THE PROGRAM. I HEREBY CONSENT/GIVE MY PERMISSION TO PARTICIPATE IN THE **PATHWAY TO HEALTH AND SCIENCE EDUCATION PROGRAM**. I UNDERSTAND THAT PARTICIPATION INCLUDES ATTENDANCE AT ALL SESSIONS OF THE REQUIRED ACTIVITIES OUTLINED IN PROGRAM DESCRIPTIONS AND I FURTHER UNDERSTAND THAT THERE WILL ALSO BE PARTICIPATION IN OTHER ACTIVITIES AS DESCRIBED IN THE PROGRAM. SAINT LUKE'S COLLEGE OF HEALTH SCIENCES IS GIVEN PERMISSION TO REPRODUCE FOR PUBLICATIONS AND INTERNET USE ANY PHOTOS TAKEN AT PROGRAM FUNCTIONS.

APPLICANT SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE _____ DATE _____
(PLEASE SIGN IF YOU ARE A PARENT OR GUARDIAN OF AN APPLICANT UNDER EIGHTEEN YEARS OF AGE)

FEDERAL FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT

I HEREBY CONSENT TO THE DISCLOSURE OF STUDENT INFORMATION RECORDS MAINTAINED BY SAINT LUKE'S COLLEGE OF HEALTH SCIENCES AND/OR THE PUBLIC SCHOOLS. THIS INFORMATION WILL BE MAINTAINED IN A CONFIDENTIAL MANNER AND WILL BE USED ONLY FOR THE PURPOSES OF THE COLLEGE'S EVALUATION. USE IS CONSISTENT WITH THE FEDERAL FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT, OR OTHER STATE OR FEDERAL LAWS, REGULATIONS, OR POLICIES. I UNDERSTAND THAT THIS PERMISSION MAY BE WITHDRAWN AT ANY TIME. SAINT LUKE'S COLLEGE OF HEALTH SCIENCES IS GIVEN PERMISSION TO REPRODUCE FOR PUBLICATIONS AND INTERNET USE ANY PHOTOS TAKEN OF MYSELF OR MY CHILD AT PROGRAM FUNCTIONS.

APPLICANT SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE _____ DATE _____
(PLEASE SIGN IF YOU ARE A PARENT OR GUARDIAN OF AN APPLICANT UNDER EIGHTEEN YEARS OF AGE)

I CERTIFY THAT THE INFORMATION SUBMITTED IN THIS APPLICATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE.

STUDENT SIGNATURE _____ DATE _____

PLEASE RETURN TO:
PATHWAY TO HEALTH AND SCIENCE EDUCATION PROGRAM
SAINT LUKE'S COLLEGE OF HEALTH SCIENCES
624 WESTPORT ROAD
KANSAS CITY, MO, 64111

ALTERNATIVELY, ALL COMPLETED APPLICATION DOCUMENTATION CAN BE SENT VIA E-MAIL AS AN ATTACHMENT TO
PATHWAYPROGRAM@SAINTLUKESCOLLEGE.EDU