Aspire 2 Inspire Foundation, Inc. & The Kappa Psi Graduate Chapter of
Omega Psi Phi Fraternity, Inc.

DC Rhinos Mentoring Program
Student Application Form

Please Print

Student Information

Name_____

Address_____

City_____ State_____ Zip_____

Date of Birth / / _____School_____Grade____Shirt Size_____

Phone Number_____ Email _____

How were you referred to us:
Organization:_____
Name:_____
Phone: _____

What do you plan to do after graduating from high school?

___ College ___ Technical School ____ Work ____ Other ____ Undecided

Career Goal:_____

Write one paragraph explaining what you would like to get out of this program.
(On a separate sheet of paper)

Parent Information
Parent/Guardian's Name_____
Address_____ City_____ State___Zip_____
Phone _____ Email _____

Emergency contacts who may pick up the student:

Name _____ Relationship _____
Home Phone _____ Mobile _____

Name _____ Relationship _____
Home Phone _____ Mobile _____

Student Signature _____ **Date**_____

Parent/Guardian Signature _____ **Date** _____

STUDENT HEALTH HISTORY RECORD

To the parent/guardian:

The health of the student is primarily the responsibility of his parents or guardians. Kappa Psi Graduate Chapter strongly recommends annual health examinations, dental checkups, and immunizations against preventable diseases. Our policy on health and safety implies a responsibility to the participants for their protection. It also implies the right of the organization to be assured, as far as possible, that the participants are physically able to take part in activities.

Student's Name:_____
Student's Full Address:_____
_____
Phone Number:_____
Student's Birthdate:_____
Parent/Guardian's Full Name:
_____

Family Physician's Name:_____

Physician's Phone Number_____

Family Medical/ Hospital Insurance Carrier:
_____

Policy/Group Number_____

Part 1: Illnesses and Injuries ***(Circle those that apply and give appropriate detail in Part 5)***

Chronic or recurring Illnesses

Ear Infections **Bleeding/Clotting Disorders** **Hypertension** **Asthma**

Heart Defect/Disease **Musculoskeletal Disorders** **Seizures** **Diabetes**

Other:_____

Were any complicating medical problems noted in last health exam? If yes, please describe _____

_____

If your child needs any medications while at this event, please indicate the medicine, dosage and times to be given in space provided below (part 6). All medications must be in their original containers. Your signature here authorizes the adult in charge to administer such medications as indicated.

Parent/Guardian Signature:_____ **Date:** _____

Part 2: Allergies ***(Circle all that apply and specify nature of allergic reaction.)***	Part 3: Immunizations
Animals_____ **Hay Fever**_____ **Pollen**_____ **Food**_____ **Drugs**_____ **Insect Stings**_____ **Plants**_____ **Other *(specify)***_____ _____	Are all of the Student's immunizations up to date? Yes _____ No _____ (*If not, please explain in Part 5)* **Date of last: DPT**_____ **Tetanus**_____
Part 4: Other Health Conditions: *(Check those that apply)* Bed Wetting___ Emotional Disturbance___ Fainting___ Hearing Impairment___ Constipation___ Dental Appliances___ Nosebleeds___ Sleep Disturbances___ Motion Sickness___ Special Dietary Needs___ Wears glasses or contacts___ Menstrual Cramps___ Sickle Cell Trait or Disease___ **Other (*specify)***_____ _____	Part 5: Notes ***(Please explain any items that are noted in previous sections. Indicate any information useful to the adult in charge in relation to any of these health conditions. Also indicate any activities to be restricted.)***
Part 6: Medication Directions: **Please give detailed directions for any medications to be given to your child. Include dosage and times.**	I know of no reason(s) other than the information on this form, why my son should not participate in activities. **Parent/Guardian Signature** _____

PARENT AUTHORIZATION FOR MEDICAL EMERGENCY TREATMENT

(Sign ONE section only.)

In case of medical emergency, I understand every effort will be made to contact parents or guardian of the child. In the event I cannot be reached, I hereby give permission to the physician selected by authorized representative(s) of Kappa Psi Graduate chapter to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child. Student's Name_____ Parent/Guardian Signature _____ Address_____ _____ Phone_____ Date_____	***(If you decline to authorize medical care for your child without prior consent)*** I have been offered the opportunity to authorize emergency medical care as set forth (on left) and decline to authorize said emergency medical care without my approval and accept such complications as may occur should said medical care be needed and unavailable due to my being unavailable to provide the same. Student's Name_____ Parent/Guardian Signature _____ Address_____ _____ Phone_____ Date_____