2019-2020

DEADLINE: March 22, 2019

Hancock County Technical Center

New Student Application

(Please complete this application in blue or black ink)

Student Name: _____ Date of Birth:_____ Gender ____M ____ F

How to Apply

- ☐ Complete application with all appropriate information and signatures (both student & guardian) and submit to your guidance counselor
- ☐ Optional visit to the program(s) to which you are applying- March 18, 2019
- ☐ Answer essay question
- ☐ Completed personal and emergency contact information
- ☐ Completed Consent, Health, & Field Trip Forms
- ☐ Include Immunization Records (with exemptions)
- ☐ Counselor page completed and sent to HCTC with completed application and the following:
  - Transcript
  - Most Recent Report Card
  - Attendance & Disciplinary Records
  - NWEA & PSAT Scores
  - Custody Documents that may apply

The information listed below will not be used when considering admission decisions to a program- it will only be used for state reporting.

Student Name _____ **State ID#:** _____

Social Security Number (optional): _____

Gender: ___M ___F (Optional)

Home Language: ___English ___Other (please list): _____

Race: ___White ___ Native Hawaiian/Other Pacific Islander ___Asian
___Black/African American ___ American Indian/Alaskan Native

Ethnicity: ___Hispanic/Latino ___Not Hispanic/Latino

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(Please complete this application in blue or black ink)

Student Name _____

Sending School: _____ Grade for 19/20 School Year: ___10 ___11 ___12

First Choice Program: _____

Second Choice Program: _____

Personal Information

Student Name: _____

Residence Address:

_____

Street Number & Name

_____

City State Zip

Mailing Address (if different from above):

_____

Street Number & Name

_____

City State Zip

Home Phone: _____ **Student Cell:** _____

Student Email: _____

Parent/Guardian Information

Primary Guardian: ___Mother ___Father ___Other: _____

Name: _____

Last First Middle

Cell Phone: _____ **Email Address:** _____

Work Phone: _____ **Employer:** _____

Secondary Guardian: ___Mother ___Father ___Other: _____

Name: _____

Last First Middle

Mailing Address (if different from student):

_____

Street Number & Name City State Zip

Cell Phone: _____ **Email Address:** _____

Work Phone: _____ **Employer:** _____

Home Phone: _____

I am applying for the Bridge Academy: ☐ **Yes** ☐ **No**

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Emergency Contact (1)

Last Name	First Name	Relationship to Student	Phone

Emergency Contact (2)

Last Name	First Name	Relationship to Student	Phone

Release of Records

I, the undersigned, hereby give permission for _____ High School to release the school records of _____.

High School Name

Student Name

Such records include, but are not limited to, course grades, discipline records, standardized test results, 504 Plans, IEP and/or PET records, attendance records, school health records, records of extracurricular activities, and psychological reports.

Signature of Parent/Guardian Date

I approve this application and verify that the information is complete and correct.

Signature of Parent/Guardian Date

Signature of Applicant Date

It is the policy of the ELLSWORTH SCHOOL DEPARTMENT that no person shall be excluded from participation in, denied the benefits of, or otherwise discriminated against under any program, including employment, because of race, color, religious creed, sex, age, national origin, ancestry, marital status, sexual orientation, disability (including, but not limited to, mental retardation, past or present history of mental disorder, physical disability or learning disability), genetic information, or any other basis prohibited by Maine state and/or federal nondiscrimination laws.

The ELLSWORTH SCHOOL DEPARTMENT does not unlawfully discriminate in employment and licensing against qualified persons with a prior criminal conviction. Inquiries regarding the ELLSWORTH SCHOOL DEPARTMENT's nondiscrimination policies and practices should be directed to Superintendent Daniel Higgins, 207-664-7100 or dhiggins@ellsworthschools.org Inquiries regarding race, color, national origin, age, sex and/or disability should be directed to the U.S. Department of Education, Office for Civil Rights, 33 Arch Street, Suite 900, Boston, MA 02110-1491; telephone number (617) 289-0111; fax number (617) 289-0150; TTY/TDD (877) 521-2172. The ELLSWORTH SCHOOL DEPARTMENT is an equal opportunity/affirmative action employer.

ESSAY QUESTIONS

Please answer the following question thoroughly in your own handwriting and in ink.

1. PLEASE TELL US A LITTLE BIT ABOUT YOURSELF AND WHY YOU WOULD LIKE TO ATTEND HCTC:

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Recommendation Form & Counselor Checklist

Counselor Checklist

- ☐ Articulation Agreements reviewed with student on _____ by _____
  Date Name
- ☐ Transcript
- ☐ Most Recent Report Card
- ☐ NWEA and PSAT Scores
- ☐ Cumulative Attendance Report
- ☐ Cumulative Disciplinary Records
- ☐ Custody Documents that may apply
- ☐ Counselor Signature
- ☐ Statement of Support

_____
Student Name

_____
Counselor Name

_____
Counselor Signature Date

This student is applying for the Bridge Program: ☐ **Yes** ☐ **No**

Grade 9 NWEA Scores: _____ **Reading** _____ **Math**

Grade 10 PSAT Scores: _____ **EBRW** _____ **Math**

Statement of Support

(To be completed by Counselor, Principal or other school personnel)

_____

_____

_____

_____

_____

_____

_____

_____

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_____

_____

_____

_____

_____
Signature Position

EXCELLENCE IN TEACHING AND LEARNING

SCHOOL SPONSORED FIELD TRIP RELEASE FORM

All field trip notices and descriptions will be communicated with parent in advance of the scheduled trip. Communication will come directly from the program instructor.

STUDENT NAME: _____

My child, _____, has my permission to attend all school-sponsored field trips. I will communicate directly with the program instructor if my child has any medical or unique circumstances that may require special assistance during the field trip.

MEDICAL INFORMATION

_____ My child takes medication during school hours.

_____My child has _____allergy and requires _____medication or special care.

_____My child has a condition that may interfere with participation in some field trips. Please explain below.

MEDICAL TREATMENT

I hereby give permission the HCTC staff to obtain emergency medical treatment for my minor child. I hereby authorize any health care professional or hospital to provide my child appropriate emergency care.

_____ _____ _____ _____

Print Parent/Guardian Name Parent/Guardian Signature Phone # Date

Should we not be able to reach a parent/guardian in case of an emergency, please list an alternate emergency contact. _____ _____ _____

Emergency Contact Relationship Telephone #

Please return this completed form to the HCTC school office

EXCELLENCE IN TEACHING AND LEARNING

STUDENT NAME _____

INTERNET IMAGE PERMISSION

Hancock County Technical Center will post digital pictures of students on its web sites and Facebook pages. Please complete and sign the statement below:

☐ I **do** give permission

☐ I do **not** give permission

Parent Signature _____ Date _____

NEWSPAPER / TELEVISION PERMISSION

This form also serves as permission for the Ellsworth American weekly newspaper and local news channels to use your child's picture.

☐ I **do** give permission

☐ I do **not** give permission

Parent Signature _____ Date _____

Hancock County Technical Center Health Update

Student Name: _____ **Date of Birth:** _____ **Grade:**____

Please help us to provide your child with a healthy school experience by completing this confidential survey. **Information will be shared only on a need to know basis.**

The Health Office will have Tylenol, Advil, Pepto Bismol, Tums, Benadryl and cough drops available on an as needed basis for your child throughout the school year. These will be **dispensed by the School Nurse or the Administrative Assistant only.** Please sign if you want your child to be able to obtain these medications. Your child **WILL NOT** be able to get these unless we have a signature below*.

Please check the following conditions that apply to your child. Include a brief explanation and any dates where appropriate in the space below (you may use the back if necessary). Please notify the school nurse with any concerns/questions.

__**No known health problems**

__Allergy bee sting **(circle all that apply)**
- Rash – mild or severe
- Swelling at site of sting
- Breathing problems
- Epipen/benadryl **(need MD order)**

__Allergy to food **(circle all that apply)**
- Rash – mild or severe
- Breathing problems
- Epipen/benadryl **(need MD order)**

__Allergy to medication **(*please list)**

__Asthma **(circle all that apply)**
- Exercise induced
- Currently carries inhaler **(list)**
- History of asthma, not currently active

__Attention Deficit Disorder/Attention Deficit Hyperactive Disorder

__Autism

__Cystic Fibrosis

__Diabetes **(Insulin or Diet controlled)**

__Hearing/Vision Problems **(please explain)**

__Heart Condition **(*please explain)**

__Seizures **(*list medication and explain)**

***Explanations:**_____
_____
_____

Con't_____
_____
_____
_____
_____
_____

Other Pertinent Information (please list):
_____
_____
_____
_____
_____

List all prescribed medications your child takes on a regular basis.
_____
_____
_____
_____
_____
_____

_____
***Guardian Signature** **Date**

Thank you for your help and let's have a healthy school year!