



School \_\_\_\_\_ Parish \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_ Grade \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Currently overall GPA \_\_\_\_\_

Home Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_

Ethnic Origin \_\_\_\_\_ Gender \_\_\_\_\_

List all high school science classes you have completed or are currently enrolled in, and the letter grade received:

List any health careers that you are interested in:

<i>Course</i>	<i>Grade</i>	
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please circle your T-shirt size:    S    M    L    XL    XXL    XXXL

Please check to verify that all of the necessary components are included with this application:

- One** letter of recommendation (Please do not include several letters)
- A copy of your most recent transcript signed by your guidance counselor.
- A COMPLETE One-Page essay explaining why you should be considered for this program and what you would like to learn by participating in this program.

**Failure to include all of the necessary information will exclude the applicant from being considered for the program.**

I have answered all of the information on this application truthfully and to the best of my knowledge.

Student signature \_\_\_\_\_ Date \_\_\_\_\_

As the parent or guardian of the aforementioned student, I have read the information regarding *A Day with the Doctors Program* and fully understand the terms and conditions of participation as indicated.

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

*Application deadline is February 26, 2010*

*Mail your signed application, a copy of your transcript, a letter of recommendation and one-page essay to:*

**Elizabeth Tamor**

**Southeast LA AHEC; 1302 JW Davis Drive; Hammond, LA 70403**

**Phone: 985.345.1119    Fax: 985.345.1157**

**Emergency Information and Authorization for Medical Treatment**

Student name \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

City, State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

Insurance company \_\_\_\_\_ Policy number \_\_\_\_\_

Insurance company phone \_\_\_\_\_

Emergency Contacts:

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Work phone \_\_\_\_\_ Home Phone \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Work phone \_\_\_\_\_ Home Phone \_\_\_\_\_

3. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Work phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Medical Information: (Check only if condition is present or recurring.)

\_\_\_\_\_ Diabetes                      \_\_\_\_\_ Asthma                      \_\_\_\_\_ Heart Condition

\_\_\_\_\_ Hemophiliac                      \_\_\_\_\_ Hearing Aid                      \_\_\_\_\_ Wears Glasses

\_\_\_\_\_ Neuro/Muscular Problem                      \_\_\_\_\_ Allergy

\_\_\_\_\_ Other, please specify \_\_\_\_\_

If any are checked please explain \_\_\_\_\_

\_\_\_\_\_

Is the student on any type of medication? \_\_\_\_\_ yes    \_\_\_\_\_ no

If yes, what is the dosage? \_\_\_\_\_

\_\_\_\_\_

In case of a serious illness, I hereby authorize hospital officials to make whatever arrangements necessary and to contact me immediately. I understand that it remains my responsibility to make any future changes in the information on this medical form as the need arises, by contacting Southeast Louisiana AHEC. Otherwise, this authorization will remain in effect as it appears this date. Neither Southeast Louisiana AHEC nor LSU Health Sciences Center – New Orleans assume responsibility for medical charges.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_