



Valley Academy for Career and Technology Education

SKILLS FOR TODAY, CAREERS FOR A LIFETIME

THIS BOX FOR OFFICE USE ONLY
Entry Date:
Entry Code:
State ID#
SM Entry Date Initials

STUDENT APPLICATION FORM FOR CENTRAL CAMPUS PROGRAMS

Select Program for Application:

- Certified Nursing Assistant/Phlebotomy (full year)
Certified Nursing Assistant (one semester)
Phlebotomy (one semester)
Construction - 1 or 2
Cosmetology (Hairstyling) 1
Culinary - 1 or 2 Fire Service
Fire Science
Law Enforcement - 1 or 2
Pre-Engineering - 1 or 2
Teacher Training - 1 or 2

PLEASE COMPLETE FULLY AND PRINT ALL REQUESTED INFORMATION

Student Name: First Last MI

Date of Birth Place of Birth (City/State)

Gender: Male Female

Origin/Ethnicity (check one)

- American Indian or Alaska Native
Asian
Black/African American
Caucasian
Hispanic/Latino
Native Hawaiian or Pacific Islander

Physical Address (Include City, State, ZIP)

Mailing Address (Include City, State, ZIP)

Student Cell Phone: Email Address:
\*\*\*This phone number and email address will be used to contact student as well as automated notifications\*\*\*

Current High School of Attendance

Expected Year of High School Graduation

EXTRA CURRICULAR INVOLVEMENT

Please list all sports, clubs, and activities (school/community) that you will be involved in next school year.

Fall Semester (August - December)

Spring Semester (January - May)

Blank lines for listing activities

The Valley Academy for Career and Technology Education seeks to have a diverse student body. The school does not discriminate in admissions, employment, or in any of its educational programs or activities on the basis of race, color, national or ethnic origin, ancestry, religion or religious creed, disability or handicap, gender, gender identity and/or expression, or sexual orientation.

## FAMILY INFORMATION

Student lives with: \_\_\_\_\_

Mother/Guardian Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Mother's Mailing Address \_\_\_\_\_

E-mail Address \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Father/Guardian Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Father's Mailing Address \_\_\_\_\_

E-mail Address \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### EMERGENCY CONTACT OTHER THAN PARENT/GUARDIAN

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

### STUDENT EMERGENCY INFORMATION

Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Provider: \_\_\_\_\_ Policy # \_\_\_\_\_

Please check if student has any of the follow health conditions, and include medication(s) taken.

\_\_\_\_ ADD/ADHD \_\_\_\_\_

\_\_\_\_ Allergies (specify) \_\_\_\_\_

\_\_\_\_ Asthma \_\_\_\_\_

\_\_\_\_ Diabetes \_\_\_\_\_

\_\_\_\_ Endocrine Disorder \_\_\_\_\_

\_\_\_\_ Gastrointestinal \_\_\_\_\_

\_\_\_\_ Hearing/Ear Disorder \_\_\_\_\_

\_\_\_\_ Heart Condition \_\_\_\_\_

\_\_\_\_ Migraines \_\_\_\_\_

\_\_\_\_ Vision (glasses/contacts) \_\_\_\_\_

\_\_\_\_ Other \_\_\_\_\_

\_\_\_\_ Medication currently being taken \_\_\_\_\_

### SPECIAL ACCOMODATIONS

Has student ever been evaluated to determine if he/she is eligible for special education and related services?    Yes \_\_\_    No \_\_\_

If yes, did the student qualify for services?    Yes \_\_\_    No \_\_\_

My family qualifies for Free and Reduced Lunch:    Yes \_\_\_    No \_\_\_

Is either parent/guardian currently employed with Yavapai College?    Yes \_\_\_    No \_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Student Signature: \_\_\_\_\_

Date: \_\_\_\_\_