

I. Parent / Guardian Information

→To be completed by the student's parent or guardian

Mother or Female Guardian Name: _____
Last *First* *M.I.*

Address: _____
Street *Apartment/Unit #*

City *WA* *Zip*

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Occupation: _____

Do you currently hold a Bachelor's Degree? Y N Email: _____

Father or Male Guardian Name: _____
Last *First* *M.I.*

Address: _____
Street *Apartment/Unit #*

City *WA* *Zip*

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Occupation: _____

Do you currently hold a Bachelor's Degree? Y N Email: _____

II. Income Information*

→To be completed by the student's parent or guardian

→Please provide a copy of your most recent 1040 or 1040A Income Tax Return OR complete the following

TOTAL HOUSEHOLD YEARLY TAXABLE INCOME: \$ _____

I certify that the amount stated above was the taxable income from last year's tax form. I understand that this amount is being used as one of the eligibility criteria for the College Bound program as defined by the Federal Register CFR part 645.6.

Signature: _____ Printed Name: _____ Date: _____

**This information is strictly for verification of income as it pertains to determining student eligibility for the College Bound program. It will be kept in complete confidence and a secure location in the program office. No information will be given to other parties without written permission from the above signer.*

Participant Health Information

→This information will be used to provide medical professionals with accurate information about your child in the case that care is needed.

Student Name: _____
Last *First* *M.I.*

Height: _____ Weight: _____ Date of Birth: _____ Glasses/Contacts? _____

Does your child suffer from any physical problems or disabilities that we should be aware of?

Mark any of the following that apply:

<input type="checkbox"/> Bites/Stings	<input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> Kidney Condition
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Sinus	<input type="checkbox"/> Allergies (Please specify) _____
<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Heart Condition	_____
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Other (Please specify) _____	_____

Please specify any special circumstances
Upward Bound should be aware of: _____

Please list current medications: _____
Name of medication *How often taken?*

Medical Care Information

→This information will help College Bound to provide the most desirable care in the case of an emergency.

Choice of Hospital in case of emergency: _____

Physician Name: _____ Phone: _____

Do you have medical insurance? Yes No

If YES, Name of Insurance Company: _____

Policy Number: _____ Insurance Phone: _____

First Aid Kits

→The following are over-the-counter medications/items that are included in our first aid kits. Please check the items that you DO NOT give us permission to administer to your child. Medications will only be administered as needed by designated staff. Your signature indicates permission to administer all unchecked items below.

<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Eye Drops	<input type="checkbox"/> Cough Drops	<input type="checkbox"/> Antibiotic Ointment
<input type="checkbox"/> Iodine	<input type="checkbox"/> Eye Wash	<input type="checkbox"/> Vaseline	<input type="checkbox"/> Alcohol Cleaning Pads
<input type="checkbox"/> Ipecac Syrup	<input type="checkbox"/> Laxative	<input type="checkbox"/> Hand Sanitizer	<input type="checkbox"/> Pain Reliever (e.g. Ibuprofen)
<input type="checkbox"/> Anti-Diarrhea Pills	<input type="checkbox"/> Antacid Tablets	<input type="checkbox"/> Antibiotic Ointment	<input type="checkbox"/> Bactine First Aid Liquid
<input type="checkbox"/> Dramamine (anti-nausea)		<input type="checkbox"/> Hydrocortisone Cream	

Signature

→In the event of accident or emergency illness, while my child is attending the College Bound program, I hereby authorize and give my consent to the Metropolitan Development Council's College Bound staff to arrange emergency medical, dental or hospital treatment as required for the health and well being of the above named student. By signing below, you certify that all the above information is correct to the best of your knowledge.

Parent Signature: _____ Date: _____

→ I certify that my answers are true and complete to the best of my knowledge. If this application leads to acceptance into the College Bound program, I understand that false or misleading information in my application or interview may result in my dismissal.

Student Signature: _____ Date: _____

Parent Signature: _____ Date: _____

If you have completed the above items, please submit your application to your school's College Bound teacher. You will be contacted by an College Bound staff member to schedule an interview.