

# WEST VIRGINIA NURSING ACADEMY

## STUDENT APPLICATION

A COLLABORATIVE EFFORT SUPPORTED BY THE WEST VIRGINIA CENTER FOR NURSING AND

### PURPOSE AND INSTRUCTIONS

### ADMISSION REQUIREMENTS

### STUDENT INFORMATION

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FIRST NAME	MIDDLE INITIAL	LAST NAME	NICKNAME
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BIRTH DATE (MM/DD/YYYY)	HOME PHONE NUMBER	CELL PHONE NUMBER	EMAIL ADDRESS
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STREET ADDRESS/PO BOX			
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CITY	STATE	ZIP CODE	COUNTY
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SCRUB SIZE (PLEASE SELECT ONE)

MEDICAL PROBLEMS AND/OR MEDICATIONS

**SCHOOL INFORMATION**

NAME OF SCHOOL CURRENTLY ATTENDING	CURRENT GRADE/CLASS LEVEL IN SCHOOL			
SCHOOL ADDRESS	CITY	STATE	ZIP	COUNTY

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**CURRENT OVERALL GRADE POINT AVERAGE****EMERGENCY CONTACTS**

In case of medical emergency, staff must be able to contact a parent/guardian or other designated emergency contact authorized to approve medical treatment for the student. Please provide current and accurate information and assure that you and/or your back up contact are always available while the student is participating in Nursing Academy activities.

PRIMARY EMERGENCY CONTACT NAME	RELATIONSHIP TO STUDENT
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**STREET ADDRESS, CITY, STATE, ZIPCODE**

HOME PHONE NUMBER	CELL PHONE NUMBER	WORK PHONE NUMBER
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SECONDARY EMERGENCY CONTACT NAME	RELATIONSHIP TO STUDENT
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**STREET ADDRESS, CITY, STATE, ZIPCODE**

HOME PHONE NUMBER	CELL PHONE NUMBER	WORK PHONE NUMBER
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SCHOOL COUNSELOR/TEACHER CERTIFICATION

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SCHOOL COUNSELOR/TEACHER NAME

TITLE

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PHONE NUMBER

EMAIL ADDRESS

I CERTIFY THAT THE STUDENT APPLICANT HAS A CURRENT OVERALL GPA OF \_\_\_\_\_

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SIGNATURE

DATE

STUDENT AND PARENT CERTIFICATIONS

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STUDENT SIGNATURE

DATE

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PARENT SIGNATURE

DATE

MEDIA RELEASE

PARENT SIGNATURE

DATE

STUDENT SIGNATURE

DATE

COMPLETED APPLICATIONS MUST BE RETURNED BY:

Questions? Contact us at: