HEADMASTERS
SCHOOL OF HAIR DESIGN

Application for Enrollment

Start date: ***January 16, 2017*** ***March 13, 2017*** ***June 12, 2017*** ***September 11, 2017*** ***November 13, 2017***

APPLICATION: *(you will need to provide a valid copy of Identification)*

Legal Name: _____ *(as on Soc. Sec. Card)*

Other Names you may go by: _____

DOB: ____/_____/_____ SSN: _____-____-_____ Cell Number: (_____)_____

Current Address: _____ City/St/ Zip: _____

Email: _____@_____

Citizenship: ☐ U.S.A. ☐ Other: _____

Are you a U.S. Military Veteran? ☐Yes ☐ No Branch: _____ GI Bill Eligible: ☐ Yes ☐ No

Ethnicity/ Race: _____ ☐ Female ☐ Male

ENROLLMENT:

Intended Course of Study: ☐ Cosmetology ☐ Cosmetology Instructor

Do you plan to or have already applied for Financial Aid: ☐ Yes ☐ No

EDUCATION: *(you will need to provide proof of Education)*

☐ HS Diploma HS Name: _____ City/ St: _____

☐ GED Certificate Date of HS Graduation/GED Certificate Received: _____

HIGHER EDUCATION:

Have you had any formal training in the practice of cosmetology in the past? ☐ Yes ☐ No

List any other higher education program or colleges you have attended in the past:

School Name: _____ Phone: (____)_____-_____

Address: _____City/ST/ Zip_____

Attended: _____ To _____ Hours : _____ Financial Aid: ☐ Yes ☐ No

Degree or Certification: ☐ YES _____ ☐ No

SIGNATURE:

By signing this application, I certify that I am in compliance with the Federal Military Selective Service Act, 50 U.S.C. sec. 453, or that I am exempt from the same. Men between the ages of 18 and 25 must be registered with the Selective Service to receive federal financial aid. You may register with Selective Services online at www.sss.gov.

Name: _____ Date:_____

Headmasters School of Hair does not and shall not discriminate on the basis of race, color, religion (creed), gender, gender expression, age, national origin (ancestry), disability, marital status, sexual orientation, or military status, in any of its activities or operations. TTY 1-800-377-3529.

Please tell us how you heard about us: (Circle one or more)

Radio Adds Newspaper Facebook Friend Other: _____

Supplemental References

Name: _____ SSN: _____

Please List References. Be sure to verify addresses, **fill in all information completely**, and list only references with which you have continued contact.

Mother

Name: _____

Address: _____

City: _____ State: _____

ZIP: _____ Phone: (___)___-_____

Employer: _____

Father

Name: _____

Address: _____

City: _____ State: _____

ZIP: _____ Phone: (___)___-_____

Employer: _____

Personal Reference

Name: _____

Address: _____

City: _____ State: _____

ZIP: _____ Phone: (___)___-_____

Relation: _____

Relative Not in Your Home

Name: _____

Address: _____

City: _____ State: _____

ZIP: _____ Phone: (___)___-_____

Relation: _____

Other

Name: _____

Address: _____

City: _____ State: _____

ZIP: _____ Phone: (___)___-_____

Relation: _____

Other

Name: _____

Address: _____

City: _____ State: _____

ZIP: _____ Phone: (___)___-_____

Relation: _____

Health Form

Name: _____ DOB: _____

Please check any of the following diseases or disorders that you may have, as well as any medications that you may be taking. **Please note this information is *optional* to provide.** We ask in cases of *emergencies* that you provide us with this information to present to any Emergency Medical Service Provider. Your information is not shared with anyone else and remains private.

____ Back Conditions

____ High/Low Blood Pressure

____ Allergies_____

____ ADD/ADHD/ other mental

____ Ulcers/ Stomach Problem

____ Headaches/ Migraines

____ Diabetes/Hypoglycemia

____ Heart Conditions

____ Bi Polar

____ Epileptic

____ Depression

____ Others _____

Please explain the nature and current treatment of any illness checked:

_____

Are you currently taking medications:_____

_____

Name of Primary Care Physician: _____

Are you pregnant: ☐ Yes ☐ No Name of Obstetrician: _____

Emergency Contact Information:

Name: _____ Home Phone: _____

Relation: _____ Work Phone: _____

OTHER INFORMATION:

Are you under a DR or Nurses care that would limit your activity or interfere with your attendance? ☐ Yes ☐ No If Yes, Please explain: _____

_____

Signature: _____ Date: _____