



HEADMASTERS

SCHOOL OF HAIR DESIGN

Application for Enrollment

Start date: November 12, 2018, January 7, 2019, March 4, 2019, June 10, 2019, September 9, 2019, November 11, 2019

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: ___-___-___ Phone: (___) _____

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: _____ Gender: Female Male Unknown

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 or 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: _____

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: _____

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	____ Diabetes/Hypoglycemia
____ High/Low Blood Pressure	____ Heart Conditions
____ Allergies _____	____ Bi Polar
____ ADD/ADHD/ other mental	____ Epileptic
____ Ulcers/ Stomach Problem	____ Depression
____ Headaches/ Migraines	____ 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: _____ 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: _____