

Admissions Application

APPLICATION CHECKLIST

- 1) **This application form**
 Completely filled out and signed.

- 2) **Official high-school transcript of all schools attended.**
 Homeschooled students not registered with a curriculum that records grades and provides transcripts are to submit information about the curriculum they used signed by a parent, listing the subjects, major texts, and grades.

- 3) **SAT or ACT scores**
 Our code numbers are 4748 for the SAT and 5001 for the ACT, if available.

- 4) **Letter of Recommendation**
 From an adult friend (e.g., a priest, pastor, family friend, teacher) who can speak from experience about your character, academic ability and personality. Submit the letter in a sealed envelope with this form.

- 5) **Health Form**

- 6) **Vaccination records**
 WCC requires a tetanus shot within 10 years prior to the start date of the program or a waiver form. Waiver forms are available from the Admissions Office upon request.

- 7) **\$100 Deposit**
 Make check payable to "Wyoming Catholic College." Check will not be deposited until applicant is accepted and is then non-refundable.

APPLICANT INFORMATION

 Last Name First Middle

 Male Female

 Nickname

Soc. Sec. No.: _____

Birth date (mm/dd/yy): _____

Address: _____
Number and Street

 City State Zip

Home phone: _____

Cell phone: _____

Email: _____

Citizenship: _____

Religion: _____

T-Shirt Size: Small Medium Large XL XXL

How did you *first* hear about Wyoming Catholic College?

- Advertising (where?): _____
- Home school conference (when, where?): _____
- WCC Employee (who, when, where?): _____
- Friend Relative Priest/Pastor WCC Student
- Other: _____

How did you learn about the PEAK 2010 camp?

FAMILY INFORMATION

Father's name: _____
Last First Middle

Home address: _____
Number and Street City State Zip

Home phone: _____ Cell phone: _____

Email: _____ Religion: _____

Occupation: _____ Employer: _____

Work phone: _____ Work email: _____

Mother's name: _____
Last First Middle

Home address: _____
Number and Street City State Zip

Home phone: _____ Cell phone: _____

Email: _____ Religion: _____

Occupation: _____ Employer: _____

Work phone: _____ Work email: _____

Check all that apply: Parents separated Mother remarried Mother deceased
 Parents divorced Father remarried Father deceased

If you checked any of the above, please indicate who should serve as the emergency contact and receive official parental correspondence: _____

Secondary Emergency Contact: Name: _____

Phone: _____ Relation: _____

ACADEMIC INFORMATION

List all high schools you have attended (*beginning with the one in which you are currently enrolled*):

Name	City, State	Dates of attendance

Expected year of Graduation: _____

Is your high school: Home school Public Private Parochial

Please list the best SAT or ACT scores from a single testing session.

SAT (was / will be) taken on _____ Combined score (out of 2400), if known: _____

ACT (was / will be) taken on _____ Combined score (out of 36), if known: _____

Additional paper may be used in answering the following questions:

CERTIFICATION

By my signature below, I certify the following: a) that the information on this form and in any documents related to my application is true and complete to the best of my knowledge; b) that I have withheld nothing about my physical or mental health either here or in having the Health Form completed. I understand that falsification or withholding of requested information on this application or any of its related components or documents will subject me prior to enrollment to disqualification from admission to Wyoming Catholic College's PEAK program or after enrollment to expulsion.

Applicant Signature

Date

A parent or legal guardian must also sign.

Parent/Guardian Signature

Date

Please mail all completed application materials to:

**Director of Admissions
Wyoming Catholic College
P.O. Box 750
Lander, WY 82520**

S T U D E N T H E A L T H F O R M

The PEAK camp will include variety of outdoor recreation activities. While the activities will be suitable for a high school-aged student of average health, applicants should be aware of the following:

- Weather conditions may include temperatures ranging from the low 40's to over 100 °F. Thunderstorms, strong winds, and intense sunlight are characteristic of summer conditions.
- Elevation of the interim campus and activity sites will be between 6,000 and 8,000 feet above sea level.
- Students may visit natural hot springs in Thermopolis State Park, hike and camp in rocky/mountainous terrain that will include travelling on steep hiking paths, off trail hiking, crossing fast-flowing streams, and camping in tents in cool overnight temperatures.
- Prior physical conditioning will greatly improve your ability to fully participate in all of the planned activities and also improve your enjoyment of these experiences.

For the safety of all participants, it is very important that the following information be provided in full.

***LEGAL GUARDIAN:** Please check YES or NO for each item. Each question must be answered and please provide date and details for all YES answers.

Student's Full Name

Height

Weight

Sex

Date of Birth

General Medical History

Does the applicant currently have or have a history of:

1. Respiratory problems? Asthma? YES NO

Is the asthma well controlled with an inhaler? YES NO

If so, please have the student bring inhaler(s) with them for the Camp.

What triggers an attack? Last episode? Ever hospitalized? _____

2. Gastrointestinal disturbances? YES NO

3. Diabetes? YES NO

Specific comments: _____

4. Bleeding, DVT (deep vein thrombosis) or blood disorders? YES NO

5. Hepatitis or other liver disease? YES NO
Specific comments: _____

6. Neurological problems? Epilepsy? YES NO

7. Seizures? YES NO

8. Dizziness or fainting episodes? YES NO

9. Migraines? Medications, frequency, are they debilitating? YES NO

For 6-9. Describe frequency, date of last episode, and severity. _____

10. Disorders of the urinary or reproductive tract? YES NO

11. Any disease? YES NO

12. Does this person see a medical or physical specialist of any kind? YES NO

If "yes" please specify the issue(s) and provide name/address of specialist _____

Questions 13 and 14 Are For Female Students Only:

13. Treatment or medication for menstrual cramps? YES NO

14. Is she pregnant? YES NO

Specific comments: _____

15. Hypertension? YES NO

16. Cardiac problems? Unexplained chest pain? YES NO

Specific comments: _____

Cardiac Screening:

*** A stress ECG is required if the applicant has any history whatsoever of a heart condition.**

Please provide a written note from your doctor stating the date of the stress ECG and the results.

Heat, Altitude

17. History of acute mountain sickness, high altitude pulmonary/cerebral edema? YES NO

When did the illness occur _____

18. History of heat stroke or other heat related illness? YES NO

Specific comments: _____

Muscle/Skeletal Injuries/Fractures

Does the applicant currently have or does he/she have a history within the past 3 years of:

19. Knee, hip or ankle injuries (including sprains) and/or surgery? YES NO

20. Shoulder, arm or back injuries (including sprains) and/or surgery? YES NO

Type of injury or surgery? When did the injury or surgery occur? _____

Is there full range of movement? Full Strength? YES NO

What is the most rigorous activity participated in since the injury/surgery. Results? _____

Specific comments: (include date of last occurrence and the effect of the problem on current activity level) _____

21. Any other joint problems? YES NO

Specific comments: (include date of last occurrence and the effect of the problem on current activity level)

22. Head Injury? Loss of consciousness? For how long? YES NO

Specific comments: (include date of last occurrence and the effect of the problem on current activity level)

23. Does the applicant have any physical, cognitive, sensory or emotional condition that would require a special teaching environment? YES NO

If yes, please describe how the condition affects you _____

Personal History (Counseling/Psychiatric/Learning Disabilities)

WCC requires that any participant with a counseling history demanding medication, hospitalization or residential treatment, display one year of stability before they will be accepted for the PEAK program.

24. Has he/she had treatment, counseling or hospitalization with a mental health professional? YES NO

25. Is he/she currently in treatment or counseling? YES NO

26. Reasons for treatment or counseling?

<input type="checkbox"/> Suicide	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> Substance abuse/chemical dependency	<input type="checkbox"/> Family issues/divorce
<input type="checkbox"/> Eating disorder (anorexia/bulimia)	<input type="checkbox"/> Depression
<input type="checkbox"/> Academic/career	<input type="checkbox"/> Other _____

Please provide **specific dates** and details of counseling Hx and medications that were prescribed:

27. Name and telephone number of therapist?

Name (_____) _____
Phone

Allergies

28. Is he/she allergic to any foods? YES NO

Describe: _____

29. Are there any dietary restrictions? YES NO

Please specify. Vegetarian Vegan Other

30. Allergic to insect bites or bee stings? YES NO

If appropriate please bring 2-3 Epi Pens or Twinjects.

Specific comments: _____

31. Any other allergies? YES NO

Specific comments: _____

32. Water on camping/hiking trips may be disinfected with iodine.

Is iodine contraindicated for this person? YES NO

Medications

33. Is he/she allergic to any medications? YES NO

If yes, please list: _____

34. Does this person plan to take prescription/non-prescription medications during the camp? YES NO

The student must understand the use of any prescription medications they may be taking. Written specific instructions are necessary. All Students who are required by their personal physician, psychiatrist or health care provider to take prescription medications on a regular basis must be able to do so on their own and without additional supervision.

Medication	Dosage	Side Effects/Restrictions	Prescribed by?	For what condition?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If medication or condition changes prior to the start of camp, please inform WCC.

Fitness (please provide details concerning the students exercise regime)

35. Does the applicant exercise regularly? YES NO

Activity _____ Frequency _____

Duration/Distance _____ Intensity Level Easy Moderate Competitive

Activity _____ Frequency _____

Duration/Distance _____ Intensity Level Easy Moderate Competitive

36. Does this person smoke? If so how much? YES NO
No smoking is allowed by any participant during the PEAK program.

37. Is this person overweight? Underweight? If so, how much? _____ YES NO

38. Swimming ability (CHECK ONE): Non-swimmer Recreational Competitive

39. Is there any other relevant medical information that we should know?
If yes, please explain: _____

40. Physical Examination

Date of Last General Exam: _____ Physician Name: _____

41. WCC requires a Tetanus Immunization within 10 years of the start date of the PEAK program.

Date of last tetanus immunization: _____

By my signature, I attest that the information in this form is complete and correct. I believe the student named on page one of this form is medically capable to participate in the PEAK camp based on the camp information provided on page 1 of this form and in the camp brochure.

Legal Guardian's Printed Name Relationship to student

Legal Guardian's Signature (_____) Telephone Number

Student's Signature

For WCC Office Use Only	<input type="checkbox"/> Initial Review OK	<input type="checkbox"/> Detailed Review OK
<input type="checkbox"/> Check Further	Date ____/____/____	Initials _____