Stage 2

ALICE LLOYD COLLEGE
*CHECKSHEET FOR STUDENT TEACHING

All appropriate forms must be fully completed in order for your application to be valid and accepted. Each item on the checklist will be verified and initialed by a member of the ALC Education Department staff.
All applications for student teaching must be submitted by the following deadlines:

For Spring semester: OCTOBER 15 **For Fall semester: March 15**

____ Application for Admission to Student Teaching

____ Medical examination by physician

____ Signed Curriculum Check sheet (Dean, Registrar and Director)

____ A Summary Sheet documenting completion of required clinical and field experiences

____ A cumulative 2.5 GPA for *ALL* college course work

____ Completed **all required professional education courses** except student teaching, with a 2.5 average and no grade lower than a C

____ Admitted to the Teacher Education Program for at least one full semester prior to applying for student teaching

____ * **Scheduled a meeting** with Education Advisor after completion of application and before submission of this application

____ Submitted updated working portfolio to Education Advisor

____ Passed all applicable parts of Praxis II

____ Updated Criminal Background Check

____ Updated Negative Drug Test

***Date and time of meeting:____ Name: ______________________**
Signature of Applicant:___________________________________Date_________

- -

This section to be completed by the Education Department
____Approved Admission
____Denied Admission (reason:____)

Signature of Education Advisor____ Date_______

Signature of Content Area Advisor______________________________________ Date_______

Signature of Director of TEP____ Date_______

***Checksheet to be submitted with Application**

Revised September 2009

ALICE LLOYD COLLEGE
APPLICATION FOR ADMISSION TO STUDENT TEACHING
(Please type or print completed form)

Name____
(Last) (First) (Middle or Maiden)

Home Address___________________________ **Telephone** Home _________________
___________________________ Cell __________________
___________________________ **Email Address** _____________________

SSN_______________________________ **Certification Area**________________________

Campus Address____

Semester ____

Please list the schools in which you would like to be assigned (the Director of Field Experiences cannot guarantee requested placement):

First Choice: ____

Second Choice: ____

Third Choice: ____

Are there any members of your immediate family (mother, father, sister, brother, sister-in-law, brother-in-law, uncle, aunt, cousin, nephew, niece) working at or attending any of these schools?
If your answer is yes, please explain:

Why would you like to be placed in these specific schools?

High School(s) attended/graduated: ____
Location____ Date of graduation____________

Can you provide personal transportation to your student teaching assignment? **If your answer is no, how do you plan to get to the assigned school?**

What would you **MOST** like to gain from your student teaching experience?

Alice Lloyd College Education Department
Personal Data Form For Student Teaching

Name____
(Last) (First) (Middle or Maiden)

Home Address____
(County) (City) (State) (Zip)
Telephone Numbers Home ____________________ Cell _______________________
High School(s) Attended ____________________________Graduation Date ______________
Scholastic/Sports/Honors/Activities____
____
____

College Major/Minor/Areas of Concentration: ____

Specific Work-Study Assignments at Alice Lloyd College: ___________________________________
____
____

Specific Skills I Possess: ____
____
____

Personal Interests and Hobbies: ____
____
____
____

Some of my Specific Beliefs about Teaching, Learning, and Classroom Management: ___________________
____
____
____
____
____

Personal Data Form

Place a check mark beside the following areas of technology and/or equipment that you feel comfortable in using.

_____Computer
_____PowerPoint
_____Excel
_____Word
_____Scanner
_____Fax Machine
_____DVD
_____VCR
_____ Other Equipment _______________

____ Laminator
____Camera
____Video Cameras
____Copier Machine
____Copying Transparencies
____Scantron
____Smart Board
____Overhead Projector

My personal/professional goals during the student teaching semester are:

ALICE LLOYD COLLEGE
Office of Teacher Education
Pippa Passes, KY 41844

MEDICAL EXAMINATION FOR APPLICATION FOR ADMISSION TO STUDENT TEACHING

Directions: Please type or print legibly in ink.

Student: Complete appropriate sections before going to your physician for examination.

Physician: This examination is at the student's expense. Please examine the student as you think necessary to determine his or her fitness for student teaching.

To Be Completed by Student

Name____ Birthdate___________________

Home Address____

Phone ( )____________________ Cell Phone ( ) ___________

Parent, Guardian, or Spouse's Name____

Address (if different)____

Phone ( )______________________ Cell Phone ( ) ___________

Hospital Preferred: ______________________ Hospitalization Insurance___________________

If the student is not an independent adult, the parent or guardian must sign the following:

I hereby consent for a qualified physician to perform any medical or surgical procedure he/she deems advisable to the welfare of (student's name) _______________________________in case of an emergency (such as acute appendicitis or injuries incurred in a accident) while the above-named student is attending Alice Lloyd College. For the purpose of the operative procedure recommended by the attending surgeon, I hereby consent to the administration of any anesthetic, general and/or local, by an anesthetist selected or approved by the surgeon. I further agree to pay all costs incurred by the named anesthetist's fee, and the cost for an ambulance for transporting the student from Alice Lloyd College, its vicinity, or his/her student teaching assignment, to a nearby hospital.

I understand the college will attempt to get in touch with me before sending the above named student to a hospital upon the advice of the college nurse and a local physician.

Signature_______________________________________ Date________________________

Relationship to Student____

STUDENT'S MEDICAL HISTORY

(To be completed by student)

Please check any of the following that you have had in the past or currently have:

____Anemia	____Hepatitis	____Polio
____Asthma	____High Blood Pressure	____Rheumatic Fever
____Chicken Pox	____Kidney Disease	____Scarlet Fever
____Diabetes	____Malaria	____Thyroid Problem
____Diphtheria	____Measles	____Tuberculosis
____Ear Infections	____Mumps	____Ulcers
____Epilepsy	____Mental or Nervous Problem	
____Hay Fever	____Venereal disease	
____Heart Disease	____Typhoid Fever	
____Whooping Cough		

Your mother's age___ (If deceased, age and cause of death)____________________________

Your father's age___ (If deceased, age and cause of death)____________________________

Do you have an allergy to food, medicine, insect stings, or anything else? If so, please describe-

____

What shots or medication do you take for your allergy? __________________________________

How often? ____

Please explain if you have had any of the following:

Surgeries____

Broken bones____

Serious illness ____

Other____

Please list any medications you are now taking:

____

Are you on a special diet? ____

Approximate date of last eye exam ______________________________

Do you wear or need glasses/contacts?___________________________

Approximate date of last dental exam ___________________________

TO BE COMPLETED BY A NURSE OR PHYSICIAN:

Vaccinations: State date when last inoculated

______Small pox	______Mumps	______TB skin test
______Diphtheria	______Polio	____neg. ____pos.
______Tetanus	______Whooping cough	
______Measles	______Influenza	
______Other		

Height__________	B/P__________	Heart sounds______
Weight__________	Pulse________	

LAB WORK: (if applicable) VDRL______ date______ pos.______ neg.______
Hemoglobin______________________
Urinalysis:______ Sugar______ Pus______
Albumin______

TO BE COMPLETED BY PHYSICIAN ONLY:

1.	head, neck	normal	abnormal
2.	mouth, throat, tonsils in or out?	normal	abnormal
3.	teeth and gums	normal	abnormal
4.	thyroid	normal	abnormal
5.	ears, hearing, tympanic membrane	normal	abnormal
6.	eyes	normal	abnormal
7.	lymph nodes	normal	abnormal
8.	chest and lungs	normal	abnormal
9.	breasts	normal	abnormal
10.	heart	normal	abnormal
11.	vascular system	normal	abnormal
12.	abdomen (hernia?)	normal	abnormal
13.	anus (hemorrhoids?)	normal	abnormal
14.	genitalia	normal	abnormal
15.	pelvic (females over 25)	normal	abnormal
16.	extremities	normal	abnormal
17.	spine, musculoskeletal	normal	abnormal
18.	skin	normal	abnormal
19.	neurologic	normal	abnormal
20.	psychiatric personality deviations	normal	abnormal
21.	menstruation (incapacitating?)	normal	abnormal

Any speech, or other serious defect which would limit or prevent normal activity?
____

Physician's Recommendation: ______(1) no restrictions
Comments: ______(2) no vigorous activity
______(3) no physical activity

Physician's signature: ______________________________ **Date:** ______________
Address: ____

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