### 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:

<table>
<thead>
<tr>
<th>For Spring semester: OCTOBER 15</th>
<th>For Fall semester: March 15</th>
</tr>
</thead>
<tbody>
<tr>
<td>____ Application for Admission to Student Teaching</td>
<td>____ Medical examination by physician</td>
</tr>
<tr>
<td>____ Signed Curriculum Check sheet (Dean, Registrar and Director)</td>
<td>____ A Summary Sheet documenting completion of required clinical and field experiences (Student Teaching beginning January 1, 2014, will be required to have completed 200 observation hours)</td>
</tr>
<tr>
<td>____ A cumulative 2.75 GPA for ALL college course work</td>
<td>____ Completed all required professional education courses except student teaching, with a 2.75 average and no grade lower than a C</td>
</tr>
<tr>
<td>____ Admitted to the Teacher Education Program for at least one full semester prior to applying for student teaching</td>
<td>____ Submitted updated working portfolio to Education Advisor</td>
</tr>
<tr>
<td>____ Passed all applicable parts of Praxis II</td>
<td>____ Updated Criminal Background Check ____ KEA-SP Membership</td>
</tr>
<tr>
<td>____ Updated Negative Drug Test</td>
<td>____ * Scheduled a meeting* with Education Advisor after completion of application and before submission of this application</td>
</tr>
</tbody>
</table>

*Date and time of meeting:____________________           Education Advisor: ____________________________

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_______

*Check sheet to be submitted with Application

Revised May 2012
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                                                                                                   ____ Laminator
_____PowerPoint                  ____Camera
_____Excel                      ____Video Cameras
_____Word                                                                                ____Copier Machine
_____Scanner                    ____Copying Transparencies
_____Fax Machine                   ____Scantron
_____DVD                                 ____Smart Board
_____VCR                                 ____Overhead Projector
_____ Other Equipment  _______________

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

Revised May 2012
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:

<table>
<thead>
<tr>
<th>Disease / Condition</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
<td>Hepatitis</td>
<td>Polio</td>
</tr>
<tr>
<td>Asthma</td>
<td>High Blood Pressure</td>
<td>Rheumatic Fever</td>
</tr>
<tr>
<td>Chicken Pox</td>
<td>Kidney Disease</td>
<td>Scarlet Fever</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Malaria</td>
<td>Thyroid Problem</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>Measles</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>Ear Infections</td>
<td>Mumps</td>
<td>Ulcers</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>Mental or Nervous Problem</td>
<td></td>
</tr>
<tr>
<td>Hay Fever</td>
<td>Venereal Disease</td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td>Typhoid Fever</td>
<td></td>
</tr>
<tr>
<td>Whooping Cough</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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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