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 (Student Teaching beginning January 1, 2014, will be required to have completed 200 observation hours)

____ A cumulative 2.75 GPA for *ALL* college course work

____ Completed **all required professional education courses** except student teaching, with a 2.75 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

____ Submitted updated working portfolio to Education Advisor

____ Passed all applicable parts of Praxis II

____ Updated Criminal Background Check ____ KEA-SP Membership

____ Updated Negative Drug Test

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

***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
_____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: _____