

## ALTOONA BEAUTY SCHOOL, INC.

### Admissions Check-off List

Dear Prospective Student,

Deadline for Submission: \_\_\_\_\_

The following is your check-off list to be **completed** before you can be accepted for enrollment into any program at the Altoona Beauty School, Inc. Please make certain that you complete all forms in the Admissions Packet and collect copies of all necessary documents to submit to the school Admissions Office.

Check-off the following after completion, collection, and submitting:

School Application

School Visits:

First Visit Date: \_\_\_\_\_ Second Visit Date: \_\_\_\_\_ Final Visit Date: \_\_\_\_\_

- |                                 |                           |                                       |
|---------------------------------|---------------------------|---------------------------------------|
| > Tour Campus                   | > Financial Planning/Aid  | > Finalize all Financial Requirements |
| > Receive:<br>School Literature | Interview                 | > Submit completed Admission Pckt     |
| Financial Aid Apps              | > Complementary Service   | > Submit all required documentation   |
| > Schedule Next ABS appt.       | > Visit Class in session  | > Complete Enrollment Agreement       |
|                                 | > Schedule next ABS visit | > Pay \$50.00 enrollment fee          |

*Your application will be reviewed, you will receive a letter of acceptance or denial within 10 business days from above date.*

Class Visitation: COSMO \_\_, MANI \_\_, ESTITICIAN \_\_, TEACHERS \_\_ (Check all that apply)

Salon Visits Form

Essay

Childcare info and/or Additional Funding Info.

Health Form

Copy Proof of Education (High School Diploma or GED)

Copy of Proof of Age (Dr. License or Birth Certificate)

Enrollment Agreement

Pay Non-Refundable Enrollment Fee of \$50.00 with credit card or money order only.

This fee must be paid on the final visit, with submission of all completed documentation. Failure to do so will delay the proceeding of the Admissions process. Once paid, the fee is not refundable.

If you have any questions please call any one of our admission representatives. We are here to assist you. Altoona Beauty School, Inc. can be reached at the following #'s:

(814)942-3141

Thank you,

Linzi J. Biesinger  
President

**ALTOONA BEAUTY SCHOOL, INC.**

**Application for Enrollment**

Please **PRINT** clearly, all information must be legible. Fill out the following information completely, as it is necessary for our files, as well as those of the state and federal agencies.

NAME: \_\_\_\_\_ SOCIAL SECURITY# \_\_\_\_\_

First MI Last  
BIRTH DATE: \_\_\_\_\_ PLACE OF BIRTH: \_\_\_\_\_  
Month Day Year City State

PERMANENT ADDRESS: \_\_\_\_\_

\_\_\_\_\_ City State Zip

Are you a U.S. Citizen? Yes \_\_\_\_\_ No \_\_\_\_\_ If no, what is your alien registration # \_\_\_\_\_  
Are you a Pennsylvania Resident? \_\_\_\_\_ How long have you lived in Pennsylvania? \_\_\_\_\_

**PARENT INFORMATION**

Fathers Name \_\_\_\_\_ Mothers Name \_\_\_\_\_  
Address \_\_\_\_\_ Address \_\_\_\_\_

Employers Phone \_\_\_\_\_ Employers Phone \_\_\_\_\_

**SPOUSE OR GUARDIAN INFORMATION**

Name \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Employers Phone \_\_\_\_\_

**IN CASE OF EMERGENCY:**

Name \_\_\_\_\_ Phone \_\_\_\_\_  
Do you have any medical problems? \_\_\_\_\_ Any Allergies? \_\_\_\_\_ Are you Pregnant? \_\_\_\_\_

**NAME AND ADDRESS OF TWO (2) REFERENCES NOT LIVING WITH YOU:**

#1. Name \_\_\_\_\_ Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
Work Phone \_\_\_\_\_ Employer \_\_\_\_\_

#2. Name \_\_\_\_\_ Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
Work Phone \_\_\_\_\_ Employer \_\_\_\_\_

**WORK HISTORY:**

Employer \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_ Phone \_\_\_\_\_  
Employer \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_ Phone \_\_\_\_\_

**EDUCATION:**

High School Diploma: yes or no      If yes: Name of High School: \_\_\_\_\_  
Highest Grade completed in High School: (Circle One) 8 9 10 11 12  
GED Certificate: yes or no

**ENROLLMENT INFORMATION:**

When do you plan to enroll at Altoona Beauty School, Inc.? \_\_\_\_\_  
What course (s) do you plan on enrolling in? (check all that apply)  
Cosmetology \_\_\_\_\_ Esthetician \_\_\_\_\_ Manicurist \_\_\_\_\_  
Electrology \_\_\_\_\_ Teacher Training \_\_\_\_\_

**POST SECONDARY EDUCATION:**

Have you ever been enrolled in Cosmetology School before?      yes or no  
If yes, complete information below:  
School Name \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Dates attended: from \_\_\_\_\_ to \_\_\_\_\_  
How many hours did you complete? \_\_\_\_\_ \* provide a transcript

Have you ever attended any Post Secondary Institution?      yes or no  
If Yes, complete information below:  
College Name \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Dates attended: from \_\_\_\_\_ to \_\_\_\_\_  
Did you obtain a degree? yes or no If yes, what what your major? \_\_\_\_\_

Because we are mandated to maintain information for Title IV of Civil Rights Act, we are asking the following information: answering these questions is optional.

Age: \_\_\_\_\_ Sex: Male or Female Race: \_\_\_\_\_ Nationality: \_\_\_\_\_  
Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Separated \_\_\_\_\_  
# of children: \_\_\_\_\_ Maiden Name: \_\_\_\_\_ Previous Married Name: \_\_\_\_\_  
*Living with:*  
Parent \_\_\_\_\_ Self \_\_\_\_\_ Guardian \_\_\_\_\_ Spouse \_\_\_\_\_ Roommate \_\_\_\_\_ Friend \_\_\_\_\_ Relative \_\_\_\_\_

**APPLICANT AFFIDAVIT (must be signed in presence of notary)**

Commonwealth of Pennsylvania, County of \_\_\_\_\_. I, \_\_\_\_\_  
being duly sworn, do depose and say that I am the person making the foregoing application,  
that I have read all the items therein carefully, and that all the statements are true and to the  
best of my knowledge and belief.

Subscribed and sworn before me  
\_\_\_\_\_ day of \_\_\_\_\_ 20\_\_

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Notary Public  
My Commission expires \_\_\_\_\_



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Student Signature

Date

**ALTOONA BEAUTY SCHOOL, INC.**

Childcare / Additional Funding Information

\* If you have children in daycare, please list your providers:

Provider #1 Business Name: \_\_\_\_\_  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

Provider #2 Business Name: \_\_\_\_\_  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

\* If you are receiving funding from another organization such as OVR, TAA, WIA, Public Assistance, or Veterans Training please list your providers:

Provider #1 Business Name: \_\_\_\_\_

Case Worker/ Counselor Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
County: \_\_\_\_\_ Comments: \_\_\_\_\_

Provider #2 Business Name: \_\_\_\_\_

Case Worker/ Counselor Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
County: \_\_\_\_\_ Comments: \_\_\_\_\_

I give my permission for the faculty at Altoona Beauty School, Inc. to call any of the above listed persons in reference to my admission and attendance at Altoona Beauty School, Inc.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## ALTOONA BEAUTY SCHOOL, INC.

### HEALTH FORM

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

All information provided is confidential. The school may request a Doctors release for your student file depending upon your responses. Your responses are voluntary and in no way affect your admissions eligibility. However, by responding accurately, we can better assess your reasonable accommodation needs if necessary.

Have you been diagnosed by a physician with any of the following conditions within the past six months?

Check all that apply:

- Alcohol, drug, substance abuse
- Carpal tunnel syndrome
- Back/Spine condition
- Cancer
- Chronic lung condition
- Diabetes
- Emphysema
- Sight impairment:
- Hearing Impairment:
- Heart Condition
- Hepatitis A, B or C
- Allergies: skin, seasonal, ect.

Please list:

- \_\_\_\_ Epileptic
- \_\_\_\_ HIV positive
- \_\_\_\_ Other, please explain: \_\_\_\_\_

List Medications taken for treatment:

Past or Current

Medications: \_\_\_\_\_

Medications: \_\_\_\_\_

Medications: \_\_\_\_\_

Medications: \_\_\_\_\_

Medications: \_\_\_\_\_

Medications: \_\_\_\_\_

Do you wear glasses? Yes or No

Do you wear a hearing aid? Yes or No

Medications: \_\_\_\_\_

Medications: \_\_\_\_\_

Medications: \_\_\_\_\_

Medications: \_\_\_\_\_

Medications: \_\_\_\_\_

Please answer the following:

Are you pregnant? yes or no (If yes, you must fill out Pregnancy Release Form)

Are all required inoculations (shots) current? yes or no

Have you ever been medically diagnosed with a learning disability, including but not limited to A.D.D., A.D.H.D., Dyslexia or other? yes or no, if yes please explain:

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Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

In case of emergency, whom should we contact?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

I understand that if any of the above information changes during my enrollment period I am responsible for notifying the Admissions Department and updating this form.

Applicant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_