

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:
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 _____

ALTOONA BEAUTY SCHOOL, INC.

Dear Salon Owner,

In order for a prospective student to be accepted for enrollment into our school they are required to visit at least two salons, spas, or nail salons.

Please fill in the appropriate information below:

#1 VISIT DATE: _____
Salon Owner or Representative: _____
Salon Name: _____
Address: _____ Phone: _____
City: _____ St: _____ Zip: _____ FAX: _____
Salon Representative Comments: _____

Student Applicant
Comments: _____

#2 VISIT DATE: _____
Salon Owner or Representative: _____
Salon Name: _____
Address: _____ Phone: _____
City: _____ St: _____ Zip: _____ FAX: _____
Salon Representative Comments: _____

Student Applicant
Comments: _____

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:

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: _____