BALL STATE UNIVERSITY

COLLEGE OF ARCHITECTURE AND PLANNING

DesignWorks 2013

July 7–19

A summer studio for college-bound high school students
Application for admission (non-degree student)

1. Complete this application by typing or printing with black ink.
2. Sections I and II must be completed by the applicant; Section III by the parents; Section IV by the high school educators.
3. This completed form must be returned with the following: a) completed treatment release, b) $35 nonrefundable application fee. If paying by check, make it payable to Ball State University, c) a current photo, d) photo/video release form.
4. All forms and application fee must be received by June 14, 2013. Application, treatment release, photo/video release and photo may be e-mailed to **msmith@bsu.edu**.

SECTION I:

1. Full Legal Name_____
Last First Middle

2. ___Female ___Male 3. Date of Birth _____/_____/_____

4. Home Address_____
Number & Street City State

_____ 5. Telephone (_____)_____
County ZIP

6. Yes No Are you a U.S. citizen? If not, name country:_____

7. Yes No Have you ever registered as an auditor (creditor waiver) at Ball State?
If yes, when? _____

8. Yes No Is there any disability or specific health problem (include speech and hearing) that may interfere with your studies or classroom attendance?
If yes, please explain: _____

9. Major academic area of interest: _____

10. Briefly describe the background you have in your chosen area. You may attach a separate sheet if needed.

_____

_____

_____

11. T-shirt Size (please circle one) S M L XL

12. Are you interested in receiving information about college credit for DesignWorks? _____

I hereby certify that the above information is complete and accurate.

Signature_____Date_____
Applicant's Full Legal Name

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SECTION II:
On a separate page please paste or electronically print a quality representation of your creative mind at work. This can be a selection of your artwork, a photograph of works that you have constructed, a writing selection, or any other two dimensional representation of *you* at *your* finest. **Do not submit original work.**

SECTION III: To be completed by parent or guardian.

Father's Name: _____ Mother's Name: _____

Occupation: _____ Occupation: _____

Home Address: _____ Home Address: _____

City, State, ZIP: _____ City, State, ZIP: _____

(If same as applicant's, write SAME) (If same as applicant's, write SAME)

PARENT/GUARDIAN CONSENT:
As the (parent/guardian), I certify that my (son/daughter/ward) has my permission to participate in this project for secondary school students. It is my understanding that (he/she) will register at and be subject to the regulations of Ball State University. I understand that, should a health emergency arise, I will be notified, but that, if I cannot be reached by telephone, such medical treatment as deemed necessary by competent medical personnel is authorized.

Signature: _____ Date: _____

SECTION IV: To be completed by high school personnel.

High School Name _____ CEEB# _____

School Address _____
Number & Street City State ZIP

Indicate expected date of high school graduation: _____

Applicant ranks _____ in a class of _____ at the end of _____ semesters.

G.P.A. _____ Combined Verbal and Math PSAT scores _____
If the applicant's exact rank is not available, approximate his/her rank and give the grade point average based on 4.0 = A system.

I personally recommend this applicant as a promising student who has high standards of character and dependability and is worthy of representing our school and community.

Signature _____ / _____ Date _____
Counselor or Principal Printed Name

Signature _____ / _____ Date _____
Teacher in Applicant's Chosen Area Printed Name

Return this form with the following:
A.) Completed treatment release form
B.) $35 *nonrefundable* application fee; checks payable to **Ball State University**
D.) Your high school transcript
E.) Photo/video release form

Return to: Ball State University
College of Architecture and Planning
Architecture Building, Room 104
ATTN: DesignWorks
Muncie, IN 47306
Phone: 765-285-5862

FOR OFFICE USE ONLY
RESIDENT_____
NONRESIDENT_____

Ball State University practices equal opportunity in education and employment and is strongly and actively committed to diversity within the community. 8769-12 umc

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PHOTO/VIDEO CONSENT AND RELEASE

I, the undersigned, irrevocably grant to Ball State University ("Ball State") the right to use my child's appearance in photographs or videotape for marketing purposes. I understand that these photographs or videotape may be used in Ball State publications, newsletters, news releases, and other printed materials, as well as in publicity materials on television and the Internet.

I understand that the photographs or videotape of my child may be edited. I understand that my child's name will not be used with the photographs or videotape unless I give express permission and at the editorial discretion of the university. I understand that my child will not be given credit for his/her appearance in the photographs or videotape.

I expressly release Ball State, its agents, trustees, officers, employees, licensees, and assigns from and against any and all claims that I or my child have or may have for invasion of privacy, defamation, or any other cause of action arising out of or relating to my child's appearance in the photographs or videotape created by Ball State.

_____
Date

_____
Signature of Parent or Guardian

_____
Printed Name of Parent or Guardian

_____
Name of Child

_____
Consent to Publish Child's Name (Signature)

Return to: Ball State University
College of Architecture and Planning
Architecture Building, Room 104
ATTN: DesignWorks
Muncie, IN 47306

BALL STATE UNIVERSITY

Amelia T. Wood Health Center
Muncie, IN 47306

CONSENT FOR TREATMENT

Name of Event:	DesignWorks
Dates:	July 7–19, 2013
Coordinator:	Joe Blalock

PARENT/GUARDIAN APPROVAL FOR TREATMENT:
I hereby authorize medical personnel of the Amelia T. Wood Health Center to administer treatment or procedures that in their judgment may be necessary for:

Name _____ Date of Birth ____/____/____ Age _____

Signature _____ Date _____
Parent, Guardian, or Next of Kin

Address _____

_____

Phone (_____)_____
Home/Work with Area Code

You will be notified should it become necessary to refer the above named patient to IU Health Ball Memorial Hospital, 2401 West University Avenue, Muncie, IN 47304, telephone number 765-747-3111.

FAMILY PHYSICIAN

Name _____

Address _____

Phone (____)_____

MEDICAL HISTORY

Insect Allergies _____

Medication Allergies _____

Food Allergies _____

Medications _____

Last Tetanus Diphtheria _____

Chronic Conditions _____
Please fill in or write "nonapplicable" for above

HEALTH INSURANCE COMPANY WHICH INSURES FAMILY AND PATIENT

Name _____

Address _____