Memorandum

To: Class of 2021

From: Jon Daly, Director of Admissions

Re: Registration forms

Greetings!

Please complete and return the enclosed registration forms as soon as possible, and **no later than May 1**.
Please also take care to complete each part of these forms. If a question on a form does not apply to you, please mark “N/A” in the space provided.

**Registration forms**
The completed and signed forms should be mailed to:
Thomas Aquinas College, Attn. Admissions Office
10,000 Ojai Rd, Santa Paula, CA 93060

**Freshman deposit**
If you have not already made your $250 freshman deposit, you can do so online at www.thomasaquinas.edu/freshman-deposit.

**Free t-shirt!**
We would like to send you your own “Class of 2021” t-shirt! Please visit www.thomasaquinas.edu/freshmantshirt and let us know your preferred size.

Please do not hesitate to call or email the Admissions Office with any questions. You can reach us at 800-634-9797 or admissions@thomasaquinas.edu.
Freshman Registration

Date __________________

Please Print

Name ___________________  First  Middle  Birthdate __________________

Birthplace __________________________________________________________

Home address ______________________________________________________

Home phone ____________________________  Cell phone __________________

Email ________________________________

Parents who have attended Thomas Aquinas College?  ☐ No  ☐ Yes  Name(s): __________________________

Siblings who have attended Thomas Aquinas College?  ☐ No  ☐ Yes  Name(s): __________________________

Relatives who have attended Thomas Aquinas College?  ☐ No  ☐ Yes  Name(s): __________________________

To which printed or online publications does your family subscribe? (optional). ____________________________

Schools Attended

<table>
<thead>
<tr>
<th>Last high school</th>
<th>Location</th>
<th>Grad. year</th>
<th>Final Transcript</th>
</tr>
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<tbody>
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<td>☐ Sent ☐ Will Send</td>
</tr>
</tbody>
</table>

Will you be taking any classes this summer?  ☐ Yes  ☐ No  ☐ Unsure  | Where? __________________________

Family Information

Father’s name ☐ Dr. ☐ Mr. ☐ Other __________________________

Address ☐ Same as student’s __________________________

Phone ____________________________  Mobile ____________________________  Email ____________________________

Employer ____________________________  Phone ____________________________

Address ____________________________

Mother’s name ☐ Dr. ☐ Mrs. ☐ Ms. ☐ Other __________________________

Address ☐ Same as student’s __________________________

Phone ____________________________  Mobile ____________________________  Email ____________________________

Employer ____________________________  Phone ____________________________

Address ____________________________

Guardian’s name (if different than parents) ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other __________________________

Address ☐ Same as student’s __________________________

Phone ____________________________  Mobile ____________________________  Email ____________________________

Employer ____________________________  Phone ____________________________

Address ____________________________

Siblings (names and ages): ____________________________________________
## Previous Work Experience

- This form will help our office make work assignments for students whose financial aid from the College includes a Service Scholarship ("work-study").
- Please check **"work"** column in those boxes to indicate work you have done in that area. If you have had classes or instruction in any of these fields, please indicate this by checking the **"class"** box. If you commonly do this type of work at home, then check the **"home"** box.

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<th>#1</th>
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<th>class</th>
<th>home</th>
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<tr>
<td>Auto repair/mechanic work</td>
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<tr>
<td>Auto parts /sales</td>
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<td>Receptionist duties</td>
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<tr>
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<td></td>
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<tr>
<td>Computer programming</td>
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<tr>
<td>Photocopying</td>
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<td></td>
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<tr>
<td>Postage machine operation</td>
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<tr>
<td>10-key calculator</td>
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<tr>
<td>Shipping clerk duties</td>
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<tr>
<td>Retail sales</td>
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<tr>
<td>Public relations</td>
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<tr>
<td>Coffee shop experience</td>
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<tr>
<td>Food-counter service</td>
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<tr>
<td>Waiter/waitress</td>
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<tr>
<td>Cook/food prep</td>
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<tr>
<td>Dishwashing</td>
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<tr>
<td>Baking</td>
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<tr>
<td>Catering</td>
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<tr>
<td>House cleaning</td>
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<tr>
<td>Health care/hospital work</td>
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<td>Library assistant</td>
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<td>Calligraphy</td>
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<td>Drawing/art</td>
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<tr>
<td>Graphic design</td>
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<tr>
<td>General yard maintenance</td>
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<tr>
<td>Landscaping</td>
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<tr>
<td>Nursery/gardening</td>
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<tr>
<td>Mowing</td>
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<tr>
<td>Sprinkler system repair/installation</td>
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<tr>
<td>Janitorial/maintenance</td>
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<tr>
<td>Carpenter</td>
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<tr>
<td>Construction</td>
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<tr>
<td>House painting</td>
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<td>HVAC</td>
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<td>Electrical</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

#2 Employer name, job title, and length of service

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

#3 Preferences

- Please rank your top three job preferences, #1 being most desired.

<table>
<thead>
<tr>
<th>Bookstore</th>
<th>Carpenter</th>
<th>Computer Maintenance</th>
<th>Driver</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grounds Keeper</td>
<td>Janitorial Work</td>
<td>Kitchen</td>
<td>Lab Assistant</td>
</tr>
<tr>
<td>Library</td>
<td>Mechanical Work</td>
<td>Office Work</td>
<td></td>
</tr>
</tbody>
</table>
Roommate Selection Questionnaire

With your happiness and comfort in mind, please answer the following questions about yourself. The information will aid the College in assigning dormitory rooms and roommates. If you need additional space, please write on the back of this page.

Age at enrollment: _______
Height: ________________

I would prefer to room with someone □ older □ younger □ same age □ doesn’t matter
Comments: ________________________________________________________________

I expect to stay up until about □ 9:00 pm–10:00 pm □ 11:00 pm □ 12:00 am or later
Comments: ________________________________________________________________

I expect to rise at about □ 6:00 am □ 7:00 am □ 8:00 am or later
Comments: ________________________________________________________________

I am □ heavy sleeper □ medium sleeper □ light sleeper

I □ snore □ do not snore

I would classify the appearance of my room as □ meticulous □ neat □ relaxed □ very casual □ slovenly
Comments: ________________________________________________________________

I am □ outgoing and talkative □ reserved and quiet □ somewhere in between
Comments: ________________________________________________________________

I like music playing in my room: □ most of the time □ often □ rarely

My musical preference is: □ Classical □ Folk □ Jazz □ Rock □ Country
Comments: ________________________________________________________________

I □ never smoke □ smoke sometimes □ smoke regularly

Do you mind being around people who smoke? □ yes □ no

Please note any sports, hobbies, or interests: __________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Please note any other factors or concerns which may influence your roommate assignment:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

admission
Emergency Information and Health Data

Name _____________________________
Birthdate __________________________

Thomas Aquinas College refers students with illness/injuries to local facilities for medical care and/or hospitalization. Your insurance should provide coverage for emergencies.

Please attach a copy of both sides of your insurance card to this page.  □ Insurance card attached   □ Unavailable
If unavailable, please note reason: ____________________________________________

Emergency Contact Information:

Mother’s name ____________________________   Cell ____________________________   Other ____________________________

Father’s name ____________________________   Cell ____________________________   Other ____________________________

Other name/relationship ____________________________   Cell ____________________________   Other ____________________________

Physical activity restrictions (please be specific): ____________________________________________

Medications you are now taking: ____________________________________________

Allergies to drugs, food, or latex: ____________________________________________

Recent surgeries or medical problems: ____________________________________________

Name of your physician: ____________________________   Phone ____________________________

Please attach available immunization records to this page.  □ Immunization records attached

Thomas Aquinas College requires proof of immunity to the following:
• Measles
• Mumps
• Rubella
• Polio
• Tdap (tetanus, dipheria, pertussis)
• Meningococcal Meningitis (one dose on or after 16th birthday)
• Varicella (chicken pox) If not vaccinated, please note approximate date of illness: ____________________________________________

Exemption: □ I hereby request exemption from the below immunizations because some immunizations are contrary to my beliefs. I am aware of the symptoms and consequences of these diseases and should I develop any one of these, I understand it may affect my ability to continue studies at the College and accept the responsibility to obtain medical help immediately. Immunizations from which requesting exemption: ____________________________________________

Exemption: □ I hereby request exemption from the below immunizations for medical reasons (please attach physician’s note). I am aware of the symptoms and consequences of these diseases and should I develop any one of these, I understand it may affect my ability to continue studies at the College and accept the responsibility to obtain medical help immediately. Immunizations from which requesting exemption: ____________________________________________

If requesting exemption, signature(s) are required:

Date _____________ Student signature ____________________________________________

Date _____________ Parent signature** ____________________________________________

**If student is under 18 years of age, parent or guardian must also sign.
California Required Meningococcal Disease Awareness Disclosure

Meningococcal disease is a serious illness caused by bacteria that can infect the blood or areas around the brain and spinal cord. Infection can lead to brain damage, disability, and rapid death.

Meningitis is the most common form of meningococcal disease. Common symptoms of meningitis include stiff neck, headache, and high fever.

The meningococcal conjugate vaccine is your best defense at preventing several types of meningococcal disease. A booster dose of the vaccine is now recommended at age 16 or older. If you were vaccinated before age 16, you need an additional dose before entering college.

Supplemental information

How many people get the disease?
Meningococcal disease is a rare but serious disease. An estimated 1,000 people get meningococcal disease each year in the U.S., with 130 to 200 of them in California. After infancy, older adolescents and young adults have the highest rate of meningococcal disease. College freshmen living in dorms are particularly at risk.

How serious is it?
Even if treated, 10–12% of people who get meningococcal disease will die from it. Of the survivors, 11–19% lose their arms or legs, become deaf or brain damaged, or suffer other complications.

How are meningococcal bacteria spread?
The bacteria are spread from person to person through air droplets. Close contact such as kissing, coughing, smoking, and living in crowded conditions (like dorms) can increase your risk of getting the disease. Overall, 5–10% of the U.S. population has the meningococcal bacteria in their throat, but only a few of them get sick. No one knows why some people get sick and others don’t.

How can I protect myself?
You can protect yourself by:
- not sharing items that have touched someone else’s mouth, such as cups, bottles, cigarettes, lip balm, and eating utensils;
- not smoking; and
- getting the meningococcal conjugate vaccine.

The Centers for Disease Control and Prevention (CDC) recommends one dose at age 11 or 12 and a booster dose at age 16. If you missed your vaccination after turning 16, get it now.

How effective are the vaccines?
Meningococcal vaccines are at least 85% effective at preventing 4 of the 5 most common forms of meningococcal disease. Ask your health care provider about the benefits and risks of meningococcal vaccines.

Source: State of California • Health and Human Services Agency

☐ I have reviewed and understand the above information.

Date __________________ Student signature ________________________________

Date __________________ Parent signature**

**If student is under 18 years of age, parent or guardian must also sign
## Health History • Student Section - 1

Name ________________________________ Date __________________

- Male   - Female  
Birthday ________ Home phone ___________________________ Cell phone ___________________________
Home address __________________________________________________________________________

Please list any current treatments (injections, physiotherapy, medication, etc.) __________________________
________________________________________________________________________________________
________________________________________________________________________________________

Have you ever had:

- ADD/ADHD
- Alcoholism/Drug addiction
- Anemia
- Anorexia
- Anxiety
- Asthma
- Blood clotting disorders
- Bruising disorders
- Bulimia
- Chicken Pox
  - Approximate Date __________
- Colitis
- Depression

- Depression medication
- Diabetes
- Emotional illness
- Epilepsy
- Head injury
- Hearing loss
- Heart disease
- Hepatitis
- Hypertension
- Kidney disease
- Malaria
- Meningitis
- Migraines/headaches
- Mononucleosis
- Multiple Sclerosis
- Pneumonia
- Poliomyelitis
- Rheumatic fever
- Sleep disorder/Insomnia
- Thyroid disease
- Tuberculosis
- Tumor/Cancer
- Typhoid fever
- Close association w/tuberculosis
Other: ____________________________

Please check yes or no to the following:

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<th>Category</th>
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<th>No</th>
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<td>Recent weight change</td>
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<tr>
<td>Amount +/- ________</td>
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<tr>
<td>Unusual fatigue</td>
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<td>❑</td>
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<tr>
<td>Speech impediment</td>
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<td>Allergies</td>
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<td>Specify___________</td>
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<td>Plants, animals, etc.</td>
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<td>Emotional</td>
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<td>Under care of psychiatrist</td>
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<td>❑</td>
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<td>Under care of psychologist ever had psychiatric care ever hospitalized for emotional problems</td>
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<td>❑</td>
</tr>
<tr>
<td>Ever medicated for emotional problems</td>
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<td>❑</td>
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<tr>
<td>Female Only</td>
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<tr>
<td>Vaginal discharge</td>
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<td>Lumps in breast</td>
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<td>Menstrual problems: irregularity</td>
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<tr>
<td>Interferes with work</td>
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<th>Muscles, Joints &amp; Bones</th>
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<td>tremor</td>
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</table>

Have you had any serious injuries, illnesses, hospitalizations, or surgeries?
☐ Yes  ☐ No

If yes, note the date, nature, and resulting complications/limitations. Please use additional sheets if necessary.
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Health History • Student Section - 2

Tuberculosis (TB) Screening Questionnaire

Have you ever had close contact with persons known or suspected to have active TB disease?

☐ Yes  ☐ No

Were you born in one of the countries listed below that have a high incidence of active TB disease?
(If yes, please CIRCLE the country, below)

☐ Yes  ☐ No

Afghanistan  Congo  Kazakhstan  Nepal  Somalia
Algeria  Côte d’Ivoire  Kenya  Nicaragua  South Africa
Argentina  Democratic People’s Republic of Korea  Kiribati  Kuwait  Niger
Armenia  Democratic Republic of the Congo  Kyrgyzstan  Lao People’s Democratic Republic  Nigeria
Azerbaijan  Bahrain  Djibouti  Latvia  Niue
Bangladesh  Dominican Republic  Lesotho  Liberia  Pakistan
Belarus  Ecuador  Libya  Lithuania  Palau
Belize  El Salvador  Equatorial Guinea  Malawi  Panama
Benin  Equatorial Guinea  Madagascar  Malaysia  Papua New Guinea
 Bhutan  Eritrea  Nepal  Maldives  Paraguay
Bolivia (Plurinational State of)  Estonia  Qatar  Marshall Islands  Peru
Bosnia and Herzegovina  Fiji  Philippines  Mauritania  Polynesia
Botswana  Gabon  Singapore  Mauritius  Portugal
Brazila  Gambia  Solomon Islands  Mexico  Qatar
Brunei Darussalam  Georgia  Sao Tome and Principe  Micronesia (Federated States of)
Bulgaria  Ghana  Senegal  Marshall Islands  Saint Vincent and the Grenadines
Burkina Faso  Guatemala  Serbia  Mauritania  Russia
Burundi  Guinea  Senegal  Mauritius  Tanzania
Cabo Verde  Guinea-Bissau  Seychelles  Mexico  Tuvalu
Cambodia  Guyana  Sierra Leone  Micronesia (Federated States of)  Uganda
Cameroon  Haiti  Singapore  Mongolia  Ukraine
Central African Republic  Honduras  Solomon Islands  Morocco  United Republic of
 Chad  India  Somalia  Mozambique  Vanuatu
China  Indonesia  South Africa  Myanmar  Venezuela (Bolivarian Republic)
Colombia  Iran (Islamic Republic of)  Sri Lanka  Namibia  Serbia
Comoros  Iraq  Sudan  Nauru  Syrian Arab Republic

*The significance of the travel exposure should be discussed with a health care provider and evaluated.
Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and/or homeless shelters)?
☐ Yes  ☐ No

Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease?
☐ Yes  ☐ No

Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol?
☐ Yes  ☐ No

If the answer is YES to any of the above questions, Thomas Aquinas College requires that you receive TB testing as soon as possible but at least prior to the start of the school year.

If the answer to all of the above questions is NO, no further testing or action is required.

Source: American College Health Association
Health History • Student Section - 3

Please answer all questions. The parental endorsement below is required of all students under 18 years of age. Please give your doctor the Physician’s Section of this form to complete. The Student Health Service does not give routine examinations. A dental checkup is also recommended.

ALL INFORMATION REQUESTED ON THIS MEDICAL FORM IS STRICTLY CONFIDENTIAL AND ESSENTIAL TO EVALUATING YOUR HEALTH STATUS.

Family Health History

Father
Living: ❑ Yes ❑ No (If deceased, please note cause) ______________________________
Age: ______ State of health: ________________ Occupation: ____________________
Note any special health problems: ____________________________________________

Mother
Living: ❑ Yes ❑ No (If deceased, please note cause) ______________________________
Age: ______ State of health: ________________ Occupation: ____________________
Note any special health problems: ____________________________________________

Brothers ❑ Yes ❑ No
Note any special health problems: ____________________________________________

Sisters ❑ Yes ❑ No
Note any special health problems: ____________________________________________

If there has been a history of any of the following illnesses in your family, please check:
❑ allergies ❑ anemia ❑ arthritis ❑ asthma ❑ blindness ❑ cancer
❑ deafness ❑ diabetes ❑ eczema ❑ epilepsy ❑ hay fever ❑ high blood pressure
❑ heart disease ❑ mental illness ❑ tuberculosis ❑ thyroid disease ❑ ulcers ❑ ________________

In case of illness and/or injury, permission is granted to examine and treat the undersigned student at the Thomas Aquinas College Health Service, and to make referrals to outside physicians and facilities.

Date _______________ Student signature ________________________________________

Date _______________ Parent signature** ________________________________________

**If student is under 18 years of age, parent or guardian must also sign.
Health History • Physician Section

This form is to be filled out by your doctor. Routine examinations are not provided by the Student Health Service. Please review before submitting to your doctor.

Student's name ____________________________ Age ______________

Weight ______________________ Height ______ P. __________ B.P. __________

Vision: R 20/____ L 20/____ Correction R 20/____ L 20/____ Color Vision ______

Please submit immunization records with this page.

Is the student at risk of Tuberculosis (TB)? □ Yes □ No

If the student is at risk of TB per the screening questionnaire in the student's health history form, a TB test is required.

Normal / Abnormal Details

Skin __________________________________________________________________________

Eyes __________________________________________________________________________

Nose __________________________________________________________________________

Mouth & Teeth _____________________________________________________________________

Throat __________________________________________________________________________

Neck __________________________________________________________________________

Thyroid __________________________________________________________________________

Breasts __________________________________________________________________________

Heart __________________________________________________________________________

Lungs __________________________________________________________________________

Abdomen __________________________________________________________________________

Back __________________________________________________________________________

Extremities ______________________________________________________________________

Genitalia _______________________________________________________________________

Rectum __________________________________________________________________________

Speech __________________________________________________________________________

Nervous System _____________________________________________________________________

Lab work if indicated:

Hemoglobin ____________________ Hematocrit ________________ Serology ________________ Other __________

Urine: Albumen __________________ Glucose ________________ Microscopic ________________ Other __________

Your appraisal of student's physical condition:________________________________________

_________________________________________________________________________________

Is the student able to physically participate in all activities and sports?_________________

The College's Food Service can accommodate some dietary restrictions recommended by a physician. Please use this space to note any dietary restrictions which this student has. __________________________

Physician signature ___________________________ Date __________ Certificate # __________

Print physician name __________________________ Phone __________________________

Address __________________________________________________________________________

I hereby consent for my doctor to provide this health information to Thomas Aquinas College. I further request that the dietary restriction information be released by the College to the College's Food Service and its employees.

Student signature ___________________________ Date __________

Parent/Guardian signature __________________________ Date __________

If student is under 18 years of age, parent or guardian must also sign.
Demographic Profile Survey

Federal law requires Thomas Aquinas College to gather the following information regarding the ethnicity and race of its students. Thomas Aquinas College will keep your individual information strictly confidential. The law only requires educational institutions to report aggregate totals for each category.

Please answer the following two questions.

1. Are you of Hispanic or Latino ethnicity?  □ Yes  □ No
   Check “yes” if you are a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin (including individuals who have their origins in Spain), regardless of race.

2. Please indicate if you are from one or more of the following races:
   □ American Indian or Alaska Native - A person having origins in any of the original peoples of North and South America (including Central America) who maintains cultural identification through tribal affiliation or community attachment.
   □ Asian - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
   □ Black or African American - A person having origins in any of the black racial groups of Africa.
   □ Native Hawaiian or Other Pacific Islander - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
   □ White - A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Name: __________________________
Media Use

It is the policy of Thomas Aquinas College that its staff, faculty or representatives may make digital, photographic, video and/or film images and records of students, faculty and staff during their time on campus and during their attendance at Thomas Aquinas College events. These images may be used for promotional purposes (news releases/stories, etc.) and for the advancement of College publications, the College webpage, and Admissions Office and Development Office publications.

I have read and understand the above policy, and I consent to the College's use of any image or record of me for these purposes.

Signature of student: __________________________________________ Date: _____________
Printed name of student: __________________________________________

If student is under the age of 18, please have a parent complete the following:

I have read and understand the above policy, and I consent to the College's use of any image or record of my son or daughter for these purposes.

Signature of parent: __________________________________________ Date: _____________
Printed name of parent: __________________________________________
The Family Educational Rights and Privacy Act ("FERPA") protects the privacy of your educational records and limits access to the information contained in those records. As a general rule*, the College may not release any of your educational records, even to your parents or guardians, unless you sign this form as indicated below. Educational records include, but are not limited to, information regarding your grades, account, financial aid, service scholarship, academic progress, health, and disciplinary actions. Without your consent, your parents or guardians might obtain this information, but only if they are claiming you as a dependent for tax purposes. You may revoke your designation at any time, but we will presume that your designation below will remain in effect through the duration of your enrollment here. If needed, additional forms can be obtained from the Registrar.

I have indicated below the individual(s) who may have information from my educational records (note: if you want to designate both parents please list both parents):

Name: ___________________________________________ Relationship: __________________________
(e.g. John Smith) (e.g. Father/Stepfather)

Address: ________________________________________ Phone: (h) __________________________

Name: ___________________________________________ Relationship: __________________________
(e.g. Carol Smith) (e.g. Mother/Stepmother)

Address: Yes Same as above Phone: (h) __________________________

If they ask, I want the above individual(s) to be informed about all of the following matters: (1) my grades and academic standing; (2) my enrollment and attendance records; (3) my financial standing with the College; and (4) the details of any disciplinary proceedings to which I may be a party. (Note: If you do not want any one or more of these matters disclosed, contact the Business Office at 805-525-4417 to obtain an alternate form.)

In addition, please inform the above-named individual(s) if (1) the College becomes aware of my being hospitalized or treated for any medical emergency, or (2) someone at the College becomes concerned about me (for missing classes, engaging in disruptive or erratic behavior, etc.). (Note: Again, if you do not want this information disclosed, contact the Business Office at 805-525-4417 to obtain an alternate form.)

I understand that the College Dean or the Dean of Students will inform the above-named individual(s) of the above information if either of them believes it is in my best interest to do so, although I understand that circumstances may make it necessary for some other College official to act on their behalf.

__________________________________________  ____________________________  ______________
Student’s name (print)  Student’s signature  Date

*The College may disclose certain of your educational records or identifiable information without your consent in such circumstances as when the disclosure
(1) Is necessary to protect your health or safety or that of others;
(2) Is in connection with your application for, or receipt of, financial aid and is necessary to determine the eligibility, amount, or conditions of such aid, or is necessary for enforcing the terms and conditions of your Payment Plan and Promissory Note (PP&PN);
(3) Is to school officials with legitimate educational interests, including to officials of other schools you are seeking or intending to enroll in;
(4) Is limited to certain "directory information," unless you have completed the College’s Directory Information Exclusion Form. The College considers the following information to be directory information: date and place of birth, permanent and campus address, phone listings, campus email address, country of origin, student photo, prior school(s) of attendance, enrollment status, class year, dates of attendance, degree received and date received, participation in officially recognized activities, jobs held on campus, including salary and dates, and senior thesis titles.

For more details, and for additional grounds for disclosure, please consult the College’s Policy on Release of Student Information, which is available from the Registrar.
Thomas Aquinas College
Billing and Mailing Information

Please indicate where the following information should be sent:

**Tuition Bills:** (Check only one box.)

- [ ] Parents/Stepparents
- [ ] Student
- [ ] Other

(Relationship)

Name/Address:

______________________________________________________________

______________________________________________________________

______________________________________________________________

Note: Have you designated this person in the Consent to Release Educational Records form?  [ ] Yes

**Bookstore Bills:** (Check only one box.)

- [ ] Parents/Stepparents
- [ ] Student
- [ ] Other

(Relationship)

Name/Address:

______________________________________________________________

(if different)

______________________________________________________________

______________________________________________________________

Note: Have you designated this person in the Consent to Release Educational Records form?  [ ] Yes

Items that may be charged to a student’s bookstore account might include: replacement and supplementary books, school supplies, personal hygiene items; photocopies, faxes, or postage purchased in the Business Office; replacement fees for lost or overdue library books; and/or large, unpaid Coffee Shop balances.

**Grades:** (Check only one box.)

- [ ] Parents/Stepparents and Student (two copies will be sent)
- [ ] Parents/Stepparents
- [ ] Student
- [ ] Other

(Relationship)

Name/Address:

______________________________________________________________

(if different)

______________________________________________________________

______________________________________________________________

Note: Have you designated this person in the Consent to Release Educational Records form?  [ ] Yes

**Parent Acknowledgment**

(If parent is responsible for guaranteeing or paying a portion of charges)

Signature of parent: ________________________________  Date: _______________
Notice of Availability of Institutional
and Financial Aid Information

In the Higher Education Act (HEA), as amended, Congress requires that colleges annually distribute to prospective students a notice of the availability of institutional information. This notice must list and briefly describe the required information and include a statement of the procedures required to obtain the information. That list is shown below. If you need any further help after reviewing the sources shown here or after contacting the individual departments, contact the Financial Aid Office at 800-634-9797, extension 5936 for additional assistance. This list is not a comprehensive list of all HEA disclosures, but only those for which a notice must be issued to prospective students.

Health and Safety

- Vaccinations Policies
- Campus Security Report, including:
  - Statistics for the 3 most recent calendar years concerning occurrences of crime on campus and on public property immediately adjacent to and accessible from the campus
  - Policies regarding procedures to report crimes committed on campus, criminal actions or other emergencies and Thomas Aquinas College’s response to such reports
  - Policies concerning the security of and access to campus facilities
  - Policies concerning campus law enforcement
  - Policies concerning alcohol and drug use
- Fire Safety Report, including:
  - Statistics and policies concerning fire safety on campus
  - Emergency response and evacuation procedures
  - Fire log

This information is available on the College’s website at www.thomasaquinas.edu/page/regulatory-information. A paper copy is available from the Business Office upon request.