

**PART B: STUDENT ELIGIBILITY
(TO BE COMPLETED BY PARENT(S) OR GUARDIAN)**

I. First Generation Eligibility

Did either parent(s)/guardian in which the student lived with, graduate from a four year college? _____Yes _____No

II. A. Income Eligibility: Upward Bound must comply with federal regulations and we must collect family income information to verify student's eligibility.

Please complete the following:

a. _____ I **DID** file income tax last year. _____ I **DID NOT** file income tax last year.

b. _____ Total number of exemptions claimed.

c. _____ Number in household.

If you did file income tax for last year, what is your family's taxable income, **NOT your gross income**. Taxable income is smaller than your total income. Please check the one that applies. If possible, please include a copy of last year's tax forms.

_____(\$0 - \$16,245) _____(\$16,246 - \$21,855) _____(\$21,856 - \$27,465)
_____(\$27,466 - \$33,075) _____(\$33,076 - \$38,685) _____(\$38,686 - \$44,295)
_____(\$44,296 - \$49,905) _____(\$49,906 - \$55,515) _____(Over \$55,516)

B. If you did not file tax forms last year, please complete the following:

Sources of income and monthly amount: _____ \$ _____

_____ \$ _____

_____ \$ _____

Number of dependents: _____

PARENT OR GUARDIAN, PLEASE SIGN AND DATE

I do hereby state that the income information I have provided is correct and truly represents my income for the previous year requested.

(Parent/Guardian Signature)

(Date)

Student Name: _____ SSN: _____

HIGH SCHOOL TRANSCRIPT PERMISSION

I, hereby give my permission to Upward Bound at Lincoln Memorial University to have access to my son/daughter's high school transcript and any other pertinent school records. I understand all information given will be kept strictly confidential.

(Parent/Guardian Signature)

(Date)

POSTSECONDARY TRANSCRIPT PERMISSION

To comply with the United States Department of Education's regulation concerning follow-up of students when they exit the program we must have permission to attain postsecondary records. Therefore, I, hereby give my permission to Upward Bound at Lincoln Memorial University to have access to my son/daughter's postsecondary academic and financial aid transcripts for the duration of their postsecondary enrollment at the institution they choose to attend.

(Parent/Guardian Signature)

(Date)

RELEASE

As a parent/guardian, I agree to save harmless the Lincoln Memorial University's Upward Bound program, Lincoln Memorial University, and their representatives from all damages and claims that may happen to my son/daughter while participating in the Upward Bound program.

(Parent/Guardian Signature)

(Date)

PERMISSION

I give my son/daughter permission to participate in the Upward Bound academic and six-week program. I understand that justification for dismissal from the program fall under the following guidelines:

1. if my son/daughter does not meet with the Upward Bound staff at school visits throughout the year;
2. if my son/daughter does not maintain at least a 2.0 GPA (with one semester probationary period);
3. if my son/daughter does not adhere to the program rules and regulations;
4. if my son/daughter has more than two (2) unexcused Saturday absences during the academic year; and
5. if my son/daughter does not follow a college preparatory curriculum.

(Parent/Guardian Signature)

(Date)

EMERGENCY MEDICAL INFORMATION

Student's Name: _____
(First) (Middle) (Last)

Home Address: _____

Home Phone Number: _____ SSN: _____

Father's Name: _____ Work Phone Number: _____

Place of Employment _____ Cell Phone: _____

Mother's Name: _____ Work Phone Number: _____

Place of Employment _____ Cell Phone: _____

Medical Insurance Company: _____

Policy Number: _____

Family Doctor: _____ Phone Number: _____

Allergies (including food and drugs):

In case of an emergency and parent/guardian cannot reached, who may we contact?

Name and phone number: _____

MEDICAL TREATMENT PERMISSION

Check the appropriate place whether you give your permission to Upward Bound program staff to authorize medical or surgical treatment in the event it is not possible to contact you in the case of an emergency. It is understood that the Upward Bound program will make these arrangements without financial responsibility.

I give my permission for the Upward Bound program staff to authorize the following treatment to _____.

Emergency Medical Treatment () Yes () No
Emergency Surgical Treatment () Yes () No

(Parent/Guardian Signature)

(Date)

Upward Bound Student Information

NAME: _____
(First) (Middle) (Last)

ADDRESS: _____

(City) (State) (Zip Code)

PHONE: (____) _____ CELL PHONE: _____

DATE OF BIRTH: _____ () Female () Male
(Month) (Day) (Year)

FAMILY INFORMATION

FATHER'S NAME: _____
(First) (Middle) (Last)

HOME ADDRESS: _____
(Street or Post Office Box)

(City) (State) (Zip Code)

OCCUPATION: _____

WORK PHONE NUMBER: (____) _____ CELL PHONE: _____

MOTHER'S NAME: _____
(First) (Middle) (Last)

HOME ADDRESS: _____
(Street or Post Office Box)

(City) (State) (Zip Code)

OCCUPATION: _____

WORK PHONE NUMBER: (____) _____ CELL PHONE: _____