ENTREPRENEUR
BUSINESS INSTITUTE
Sponsored by International Capital & Management Company®
in Partnership with The University of the Virgin Islands

INSPIRINGINNOVATION

Entrepreneur Business Institute
Student Application
June 25th – July 9th, 2017

Application Checklist

_____ An official high school transcript

_____ Recommendation letter to be completed by a teacher or counselor (See Part C)

_____ An essay on the following topic:

"What role does innovation play in entrepreneurship and business?"

(12 pt. font attached as a word document; minimum 450 words/maximum 650 words)

_____ Parent Waiver and Release Form

_____ Student Health Form

This form must be completed in full and returned to International Capital & Management Company by April 24, 2017. All information will be treated confidentially. **Applications will be reviewed once all materials are received.** If you are selected for an interview, you will be contacted to schedule an appointment. Program admission is based on academic eligibility, readiness for program services and available space.

In order to be considered as a candidate for EBI, this application must be filled out completely, including Parts A, B, C, the essay, the pre-program survey, an official high school transcript and parental waiver. All information is required and explained on the first page of this application. <u>Please note that applications will not be considered if any information is missing or incomplete.</u>

Student Application Form: (Part A)

Name: _____
Last First Middle

Physical Address:_____

Mailing Address: _____

Phone Number:_____ E-mail address:_____

Place of Birth: _____ Date of Birth: _____ T-Shirt Size _____

If not born in the U. S. of the U. S. V. I., please complete A or B below:

____A. Naturalized Citizen Date Granted: _____ (please provide copy)

____B. Permanent Resident Date Granted: _____ (please provide copy)

Gender: ___M ___F Age: _____

Name of High School: _____

Current Grade: _____ High school career path: _____

In Case of Emergency who should be contacted: _____

Emergency Contact Phone Number: _____

_____ _____
Student's Signature Date

UVI complies with affirmation action, equal opportunity, Title I, Section 504 Federal Legislation.

Parent Information Form (To be completed by Parent or Guardian): (Part B)

Kindly explain any medical, psychological, behavioral, and/or educational problems that may limit your child's successful participation in the Entrepreneur Business Institute.

In case of emergency, what procedure should be followed?

Please list and explain the use of any medication(s) that your child is currently using.

Date of your child's last physical examination:

Medical Insurance: _____ Insurance # _____

Name (Parent/Guardian)	
Relationship to Applicant	
Parent Phone Number(s)	
Parent Email Address	
Employer	
Job Title	

_____ _____

Parent's Signature Date

Recommendation Section (To be completed by a Teacher or Counselor): (Part C)

Name of Student: _____

Name of School: _____

_____ Teacher _____ Counselor If teacher, subject taught: _____

Teacher/Counselor's Name: _____

The above student is applying for admission to the Entrepreneur Business Institute. The goal of the program is to introduce eligible students to the business field with the view of extending their options in their career choice. The program expands over (2) weeks and covers entrepreneurial activities, academic instruction, and small group interaction, field trips to local businesses, college admission information as well as cultural, social and recreational activities for all participants.

Please provide a brief statement using the space below indicating why you believe this student should be admitted to The Entrepreneur Business Institute and how we can best serve his/her needs. Please specify academic/social needs, such as improving writing, math skills and/or exposure to college environment.

_____

_____

_____

_____

_____

_____

_____

Mail, Email or Hand Deliver completed applications by April 24, 2017 to:
International Capital & Management Company
1600 Kongens Gade
St. Thomas, V.I. 00802
Attn: Karen Nelson-Hughes
communityrelations@icmcvi.com

Date Completed: _____

Note: Under the Family Educational Rights to Privacy Act of 1974, the candidate is entitled to review this recommendation.

International Capital & Management Company
Private Merchant Bankers

UNIVERSITY OF THE VIRGIN ISLANDS · 1962 ·

PARENTAL WAIVER AND RELEASE

The undersigned, being a parent or authorized legal guardian of _____ ("Student"), a minor under my custody and control, hereby acknowledge and agree to the following:

1. I hereby authorize Student to attend all classes and activities associated with the Entrepreneur Business Institute©, to be conducted at the campus of the University of the Virgin Islands and various locations on St. Thomas, U.S. Virgin Islands during the period June 25th through July 9th, 2017 ("EBI Program").

2. I hereby certify that Student is fully capable of participating in the EBI program, and does not suffer from any disabilities or infirmities which would limit Student's full participation, or pose a risk of harm to either Student or others during that participation.

3. On behalf of myself, the minor, and any other persons in privity with or having a legal relationship with the minor, I agree to release, hold harmless and indemnify the EBI Program, International Capital & Management Co., LLC, the University of the Virgin Islands and their respective affiliates, representatives, agents, employees, contractors and presenters (collectively, "EBI staff"), from any claims or damages of any nature arising from or related to the Student's attendance at or participation in the EBI Program, including but not limited to claims of personal injury, property damage, wrongful death, or other damages occurring to Student or any third parties, absent the wilful conduct or gross negligence of EBI staff.

4. I further consent to EBI Staff arranging or providing emergency medical treatment to the Student at my expense in the event of any emergency illness or injury occurring to Student during participation in the EBI Program.

5. On behalf of myself, the minor, and any other persons in privity with or having a legal relationship with the minor, I agree to allow any audio, photo, video or film likeness of Student to be used by EBI staff as its sole property for any legitimate purpose, such as marketing or promotion of the EBI Program, and agree to release, hold harmless and indemnify EBI staff from any claims or lawsuits relating to the collection or publication of such likeness.

Dated: _____ _____
(Signature)

_____
(Print name)

Emergency contact telephone numbers: _____

Student medications or disabilities: _____
_____
_____

University of the Virgin Islands

Student Health Form

PHYSICAL EXAMINATION

(To be completed by medical provider)

HEALTH FORM MUST BE COMPLETED AND RETURNED TO THE UNVERSITY'S HEALTH SERVICE CENTER PRIOR TO MOVING ON CAMPUS OR REGISTERING FOR CLASSES.

MAILTO ADDRESS SHOWN AT THE BOTTOM OF PAGE 4

INSTRUCTIONS:

1. Complete Sections I and II by providing the requested information (all students 18 years of age and older).
2. If you are under 18 years of age, a parent or guardian **MUST** complete and sign Sections I and II.
3. Have any licensed medical provider fill out Section III including the required laboratory test.

I. INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH (mo / day / year)	SEX

RESIDENTIAL ADDRESS	STREET RURAL ROUTE	CITY	ISLAND / STATE

MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	ZIP CODE

PARENT OR GUARDIAN NAME	HOME PHONE	BUSINESS PHONE

PARENT OR GUARDIAN RESIDENTIAL ADDRESS (IF DIFFERENT FROM ABOVE)	STUDENT E-MAIL ADDRESS

II. MEDICAL CONSENT (to be completed by the parent or guardian)

I, the undersigned (parent or guardian) do hereby grant permission to the University of the Virgin Islands Health Service Center (personnel, medical providers and nurses, or the medical provider designated by the campus physician) to provide medical and or surgical treatment to:

_____
NAME OF CANDIDATE FOR ADMISSION

during her/his enrollment at the University of the Virgin Islands. I also grant permission for her/his hospitalization and treatment herein, if such hospitalization is necessary.

I understood that in the event of a serious illness, accidental injury or need for surgery, an attempt will be made by the University's Health Service Center to contact me by telephone. If unable to contact me, needed emergency treatment may be given as necessary in the best interest of the student.

_____ _____

SIGNATURE OF PARENT OR GUARDIAN
SIGNATURE OF STUDENT (IF OVER 18 YEARS OLD)

DATE
(mo / day / year)

PLEASE PRINT CLEARLY

Revised October 2016

University of the Virgin Islands – Student Health Form

LastName_____FirstName_____Initial_____Sex_____ DOB _____

Mailing Address _____ Phone _____ (H W C)

City _____ State _____ Zip Code _____ University ID# _____

Employer_____ Occupation _____ Work Phone_____

Emergency Contact Information

Name_____ Relationship_____ Phone _____

Name_____ Relationship_____ Phone _____

Patient Medical History Information

YES	NO	DO YOU HAVE OR HAVE YOU EVER HAD:	YES	NO	DO YOU HAVE OR HAVE YOU EVER HAD:	COMMENTS (Office Use Only)
		1. Eye trouble (***exclude*** *glasses, contact lenses)*			31. Frequent or painful urination	
		2. **ANY** allergies:			32. Blood, protein, or sugar in urine	
		3. Take any medications regularly			33. History of diabetes	
		4. Frequent, severe, or migraine headaches			34. Kidney stone	
		5. Fainting or dizzy spells			35. Hernia or rupture	
		6. Periods of unconsciousness			36. Back pain or trouble	
		7. Head injury or skull fracture			37. Paralysis or weakness	
		8. Epilepsy, seizures or convulsions			38. Foot trouble / use orthotics	
		9. Loss of memory *(amnesia)*			39. Rheumatic fever	
		10. Depression, anxiety or nervousness			40. Any bone or joint problem or injuries	
		11. Any mental condition or illness			41. Tuberculosis or positive TB test	
		12. Hearing loss			42. Sexually transmitted disease *(STD)*	
		13. Ear, nose, or throat trouble			43. Any skin conditions	
		14. Sinusitis or sinus trouble			44. Adverse reactions to vaccines / drugs	
		15. Hay fever or allergic rhinitis			45. Adverse reactions to food / insect bites	
		16. Tooth/gum trouble or current orthodontics			46. Sensitivity to chemical, dust, sunlight, etc.	
		17. Thyroid trouble			47. Eating disorder	
		18. Chronic cough or lung disease			48. Recent gain or loss of weight	
		19. Asthma or wheezing			49. Excessive bleeding or easy bruising	
		20. Unusual shortness of breath			50. Tumor, growth, cyst, or cancer	
		21. Pain or pressure in chest			51. Considered or attempted suicide	
		22. Palpation or pounding heart			52. Learning disability or speech problems	
		23. High blood pressure			53. Had **ANY** surgery	
		24. Heart trouble or heart murmur			54. Any other injury or illness not noted above	
		25. Stomach, liver, or intestinal problem	XXXX	XXXX	**FEMALES ONLY**	
		26. Gallbladder trouble or gallstones			55. Had a change in menstrual pattern	
		27. Hepatitis *(yellow jaundice)*			56. Been treated for a female disorder	
		28. Hemorrhoids or rectal disease			57. Experience painful periods or cramps	
		29. Black or bloody stools			58. Have you ever been pregnant	
		30. Constipation / Diarrhea			59. Are you currently pregnant	

I grant permission for the personnel of the UVI Health Service Center (HSC) to examine and treat me for the reasons I have presented. I agree to be responsible for all charges incurred. I hereby authorize my insurance benefits to be paid directly to UVI Health Service Center. I authorize the release of any information required to process any insurance claim or any report required by a municipality or governmental agency. I also agree to be responsible for payment of services including those not covered by my school insurance (students only) and/or insurance company, including; late fees and collection costs.

_____ _____

Signature (Parent/Guardian must sign if under 18 years old) **Date** (mo / day / year)

University of the Virgin Islands – Student Health Form

III. PHYSICAL EXAMINATION (to be completed by a medical provider)

Student Name _____ **DOB** _____/_____/_____ ____**Female** ____**Male**

Height _____ **Weight** _____**lbs** **BMI**_____ **Blood Pressure** _____ /_____ **T** ____ **P** _____ **R** ____

Distance Vision: Right uncorrected: 20 /____ Right corrected 20 / ____

Left uncorrected: 20 / ____ Left corrected 20 / ____

Color Vision: ____ normal ____abnormal

Hearing (whispered voice at 10 feet): Right ____ heard ____ not heard

Left ____ heard ____ not heard

ALLERGIES: _____ **SYMPTOMS:** _____

SYSTEMS	NL	ABNL	NA	Comments:
HEENT				
HEART				
LUNGS				
ABDOMEN				
EXTREMITIES				
NEURO				
SKIN				
GENITAL (General PE Only)				

CURRENT MEDICATIONS:

Name of Medication(s)	Dosage	How Often	Discontinued
1.			
2.			
3.			

CURRENT MEDICAL CONDITION(S) AND TREATMENT(S):

SURGICAL & PAST MEDICAL HISTORY:

ADDENDUM:

IMMUNIZATIONS: Required for all students

Polio: ____/____/____ ____/____/____ ____/____/____ (3 doses are acceptable)

Tdap: ____/____/____ (Get a Tdap Vaccine once then TD booster every 10 years)

TD: ____/____/____ ____/____/____ ____/____/____

MMR: ____/____/____ ____/____/____

Hepatitis B: ____/____/____ ____/____/____ ____/____/____

Meningococcal Quadrivalent (A, C, Y, W-135) ____/____/____ **(Mandatory for all students)**

Serogroup B Meningococcal: (Bexsero 2 doses series or Trumenba, 3 dose series: (**Recommended but not mandatory**)

MenB0 RC (Bexero) ____/____/____ ____/____/____ **or** MenB0FHbp (Trumenba) ___/____/____ ____/____/____ ____/____/____

Varicella: (A history of chicken Pox, a positive varicella antibody or 2 doses of vaccines meet the requirement):

Dose #1 ____/____/____ **Dose #2** ____/____/____ 1. ☐ History of Disease: Year _____

2. Varicella antibody Date __/___/___ Result Reactive _____ Non- Reactive____

PPD Skin Test is required for all students:

PPD or TST (Tuberculin Skin Test) ____/____/____ PPD Reading: ____/____/____ ____ mm ____ Negative ____ Positive

CXR Results (required for positive PPD): _____ ☐ INH Treatment received: ____ 3 months ____ 6 months ____ 9 months

LABORATORY TEST RESULTS:

CBC: _____ **UA:** _____ **FBS:** _____ ☐ Lab Slip Given

According to my review of systems, history and physical examination of the student:

_____She/He is fit for any form of physical activity

_____She/He should be excused from participation in strenuous physical activity

_____She/He should be excused from participation in all forms of physical activity

_____ _____

MEDICAL PROVIDER NAME (*Please Print*) **SPECIALITY AREA**

MEDICAL PROVIDER'S SIGNATURE: _____ **DATE:** _____
(mo / day / year)

MEDICAL PROVIDER'S ADDRESS: _____

_____

_____

UVI MEDICAL PROVIDER'S SIGNATURE: _____ **DATE:** _____
(mo / day / year)

UNIVERSITY OF THE VIRGIN ISLANDS

St. Croix Campus
Health Service Center
RR#1 Box 10, 000 Kingshill
St. Croix, VI 00850-9781
(340) 692-4208 (Office)

St. Thomas Campus
Health Service Center
#2 John Brewers Bay
St. Thomas, VI 00802-9990
(340) 693-1124 (Office)