

# FLORIDA HSHT STUDENT ENROLLEMENT FORM 2013-2014

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**Enrollment Date:** \_\_\_\_\_ **HSHT Site/County:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **High School:** \_\_\_\_\_

**Check one:**  **New HSHT Student**  **Returning HSHT Student**  **HSHT Program Alumni**

**Address/City/State/Zip:** \_\_\_\_\_

**Phone Number** \_\_\_\_\_ **Email** \_\_\_\_\_

**Age:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Grade:** \_\_\_\_\_  **Male**  **Female** **Ethnicity:** \_\_\_\_\_

**Parent/Guardian Name** \_\_\_\_\_

**Parent Phone Number** \_\_\_\_\_ **Parent Email** \_\_\_\_\_

**Student's Diploma Track**

**Standard**  **Option:** \_\_\_\_\_

**Student's post-secondary education/transition plan:**

**Vocational Training**  **State (Community) College/4-yr. University**  
 **Employment**  **Other (describe)** \_\_\_\_\_

**Student career interest:** \_\_\_\_\_

**Student's Employment Status:**

**Never worked**  **Currently working full time, wage** \_\_\_\_\_  
 **Has worked but is not currently working**  **Currently working part time, wage** \_\_\_\_\_

**Student's disability category (as listed in IDEA, 2004), please check the primary disability:**

- Autism (includes Asperger's Syndrome)**
- Cognitive Disability, Intellectual Disability**
- Deafness**
- Deaf-blindness**
- ED – Emotional Disturbance**
- Hearing Impairment (other than deafness)**
- Multiple Disabilities ("which cause severe educational needs" IDEA, 2004)**
- Orthopedic Impairment (Cerebral Palsy, amputation, polio, severe fractures or burns)**
- Speech or Language Impairment (communication disorders such as stuttering)**
- SLD - Specific Learning Disability (includes dyslexia and non-traumatic brain injury)**
- TBI - Traumatic Brain Injury (caused by external physical force)**
- Visual Impairment Including Blindness**
- OHI - Other Health Impairment (ADD/ADHD, asthma, diabetes, epilepsy, health conditions)**
- Other Physiological, Psychological, or Mental Disability, (please describe)** \_\_\_\_\_

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**This Project Funded By**



Revised April, 2013

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Name: \_\_\_\_\_

**Student is a recipient of:**

- SSI-Supplemental Security Income
- SSDI-Social Security Disability Insurance
- TANF-Temporary Assistance for Needy Families
- VR-Vocational Rehabilitation services
- WIA-Workforce Investment Act services (formerly JTPA; now Workforce, One Stop)
- IEP / IDEA-Individual Education Program/Individuals with Disabilities Education Act provisions
- MHO-Mental Health Outreach services
- DJJ-Department of Juvenile Justice services/involvement
- APD-Agency for Persons with Disabilities services
- DCF/Foster Care/Department of Children & Families services

**Student participates/has participated in:**

- A formal mentoring program (RAMP, Goodguides, Big Brothers/Big Sisters)
  - The Project Impact Initiative
  - The Florida Youth Leadership Forum (YLF)
  - Florida Disability Mentoring Day (DMD)
  - Career-related elective classes *or* dual-enrollment (**please list**)
- 

- School clubs (**please list**)
- 

This Project Funded By





**EMERGENCY INFORMATION FOR FLORIDA HIGH SCHOOL HIGH TECH STUDENTS**

**STUDENT'S NAME:** \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT:**

**NAME:** \_\_\_\_\_ **HOME PHONE:** ( ) \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **WORK PHONE:** ( ) \_\_\_\_\_

**RELATIONSHIP:** \_\_\_\_\_ **CELL PHONE:** ( ) \_\_\_\_\_

**GUARDIAN, IF APPLICABLE:**

**NAME:** \_\_\_\_\_ **TELEPHONE:** ( ) \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**NAME OF PHYSICIAN:** \_\_\_\_\_ **TELEPHONE:** ( ) \_\_\_\_\_

**PERFERRED HOSPITAL:** \_\_\_\_\_ **TELEPHONE:** ( ) \_\_\_\_\_

**INSURANCE:** \_\_\_\_\_ **POLICY NO.:** \_\_\_\_\_

**PARENTS: IT IS IMPERATIVE THAT ALL STUDENTS HAVE INSURANCE, MEDICATIONS NEEDED, AND BE SELF-MEDICATING TO ATTEND FIELD TRIPS!**

MEDICATIONS	DOSAGE/TIME	PHYSICIAN	TELEPHONE
<input type="checkbox"/> NONE			

**Please provide information about the student that pertains to any precautions that we need to take during program activities.**

**Special needs/conditions:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

# Florida High School High Tech Application

## Applicant Information

Name:

Current address:

City

State:

ZIP:

Email Address:

Referral Source: School System

Participant Funding: The ABLE Trust

Cell Phone:

Date of Birth:

Gender:  Female  Male

Ethnic Background:

Home Phone:

Work Phone:

## Career Interest:

Please list Careers you are interested in:

Jobs you would like to learn about?

Please list your Hobbies, Interests & Skills:

I am interested in learning about:

## Emergency Contact Information

Name:

Home Phone:

Address:

Cell Phone:

City:

State:

ZIP Code:

Relationship to Applicant:

Student Signature:

Date:

Parent/Guardian Signature:

Date:



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## MEMBER

Goodwill Industries  
International, Inc.

Commission on Accreditation  
of Rehabilitation Facilities

Florida Rehabilitation  
Association

The Mayor's Alliance

Florida Goodwill Association

United Way of Lee County

## Photo Media Release Form

Date: \_\_\_\_\_ Person: \_\_\_\_\_  
Student's Name

I hereby consent to the taking, publication and/or broadcast of photographs, videotapes and audio tapes being taken at or for Goodwill Industries of SW FL, Inc. I understand these productions may appear on television, radio and/or print.

I hereby waive all rights to claims for payment or royalties in connection with use, publication or exhibition of the above mentioned photos or tapes.

I release Goodwill Industries of SW FL., Inc., its Board of Directors and staff of any responsibility or recourse in the release of such information or taking of these photos and/or tapes.

Signature: \_\_\_\_\_  
Student

If minor or unable to sign:

Parent/Guardian Signature: \_\_\_\_\_

Relationship to Student:  
\_\_\_\_\_



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- Florida Rehabilitation Association
- The Mayor's Alliance
- Florida Goodwill Association
- United Way of Lee County



Building lives,  
families, and  
communities-  
One job at a time

**AUTHORIZATION FOR RELEASE OF INFORMATION**

NAME: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

This will authorize Goodwill Industries SW Florida to release medical, psychiatric/psychological, vocational, financial, and social information from my record in accordance with State and Federal regulations to:

<b>Information to be OBTAINED ( )</b>	<b>FORWARDED ( ) as follows:</b>
<u>    </u> Discharge Summary	<u>    </u> Social
<u>    </u> Medical	<u>    </u> Financial
<input checked="" type="checkbox"/> Vocational	<u>    </u> Other (Explain)
<u>    </u> Public Relations (newsletter, article, photo, etc.)	<input checked="" type="checkbox"/> Written
<input checked="" type="checkbox"/> Psychiatric/Psychosocial	<input checked="" type="checkbox"/> Verbal
	<input checked="" type="checkbox"/> Electronic
	<input checked="" type="checkbox"/> Audio
	<input checked="" type="checkbox"/> Video

Record to be used for Florida High School High Tech Program.

I understand that I have the right to refuse this authorization and that the facility named above is released from all legal liability that may arise from the release of the information requested. I understand that this authorization may be revoked by me at any time by written notice to Goodwill Industries of Southwest Florida, Inc., or its representative. I further understand that the information released prior to my revocation cannot be retrieved, nor can Goodwill Industries of Southwest Florida, Inc., or its representatives be held responsible for such an act.

**Prohibition on Re-disclosure:** This information has been disclosed to you from records whose confidentiality is protected by law. Any further re-disclosure is strictly prohibited.

This authorization will be valid for 365 days from the date of the student's signature as it appears below.

Student Signature \_\_\_\_\_ Date: \_\_\_\_\_

Legal Guardian Signature (if minor): \_\_\_\_\_ Date: \_\_\_\_\_

FL HSHT Representative:  
Date: \_\_\_\_\_

**FLORIDA HIGH SCHOOL HIGH TECH PROGRAM  
GOODWILL INDUSTRIES OF SOUTHWEST FLORIDA, INC.**

**FL HSHT FILE COPY**

**S TUDENT'S R IGH TS**

**You have the right:**

- ❖ To be treated in the least restrictive manner and setting for your needs
- ❖ To receive services regardless of age, race, color, religion, sex, marital status, disability, or national origin
- ❖ To be the focus of decisions of your program goals and programming of services
- ❖ To be treated with dignity and respect, free from mental/physical abuse
- ❖ To refuse services – Your participation is voluntary and other help is available.
- ❖ To help with development of program plan with your family/friend present
- ❖ To possession of personal effects, clothes, and manage your own money
- ❖ To confidentiality – No material will be given by Goodwill without expressed permission
- ❖ To review information in your file
- ❖ To a fair wage for all work done as wages are established by U. S. Department of Labor
- ❖ To refuse participation in research activities
- ❖ To know the source of payment for your program
- ❖ To participate in planning your exit/discharge from program
- ❖ To have a personal representative to help protect your rights
- ❖ To bring grievance regarding violations of basic rights to your case manager, Vice President of Career Development Services or CEO within 5 working days to resolve in writing. Final decision made by CEO of Goodwill Industries of Southwest Florida, Inc. or outside agency if not satisfied

**I understand and agree with the above Student Rights and will retain a copy for my records.**

\_\_\_\_\_  
**Student's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Legal Guardian's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**FL HSHT Coordinator's Signature**

\_\_\_\_\_  
**Date**

**FLORIDA HIGH SCHOOL HIGH TECH PROGRAM  
GOODWILL INDUSTRIES OF SOUTHWEST FLORIDA, INC.**

**STUDENT COPY**

**S TUDENT'S R IGH TS**

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- ❖ To be treated in the least restrictive manner and setting for your needs
- ❖ To receive services regardless of age, race, color, religion, sex, marital status, disability, or national origin
- ❖ To be the focus of decisions of your program goals and programming of services
- ❖ To be treated with dignity and respect, free from mental/physical abuse
- ❖ To refuse services – Your participation is voluntary and other help is available.
- ❖ To help with development of program plan with your family/friend present
- ❖ To possession of personal effects, clothes, and manage your own money
- ❖ To confidentiality – No material will be given by Goodwill without expressed permission
- ❖ To review information in your file
- ❖ To a fair wage for all work done as wages are established by U. S. Department of Labor
- ❖ To refuse participation in research activities
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\_\_\_\_\_  
**Student's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Legal Guardian's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**FL HSHT Coordinator's Signature**

\_\_\_\_\_  
**Date**



**FLORIDA HIGH SCHOOL HIGH TECH PROGRAM  
GOODWILL INDUSTRIES OF SOUTHWEST FLORIDA, INC.  
INDIVIDUALIZED CAREER / EDUCATION PLAN**

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**STUDENT INPUT**

My career interest is \_\_\_\_\_

I would be interested in a site visit to

\_\_\_\_\_

I would like to Job Shadow a person that works as a

\_\_\_\_\_

**STUDENT ACKNOWLEDGEMENT**

I participated in the development of this plan. The goals and objectives contained in this plan were established by me, with the assistance of my HS/HT Coordinator. I accept this plan and its contents and will participate in periodic reviews, updates, and modifications as necessary so that I may accomplish my post-secondary goals. It is my responsibility to maintain the agreements set forth in this plan and to work with my HS/HT Coordinator in a coordinated effort to earn my high school diploma.

Student Name: \_\_\_\_\_ Student Signature/Date: \_\_\_\_\_

HSHT Coordinator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**DEMOGRAPHIC DATA**

Address: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone No.: (     ) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Referring Agency: \_\_\_\_\_ Contact and Phone (     ) \_\_\_\_\_

Disability / Disadvantage: \_\_\_\_\_

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**FLORIDA HIGH SCHOOL HIGH TECH PROGRAM  
GOODWILL INDUSTRIES OF SOUTHWEST FLORIDA, INC.  
INDIVIDUALIZED CAREER / EDUCATION PLAN**

**STUDENT NAME:** \_\_\_\_\_

**CAREER / SCHOOL GOAL:** \_\_\_\_\_

GOALS / OBJECTIVES	RESPONSIBLE PERSON(S)	TRANSITION ACTIVITY	TIME FRAME	REVIEW DATE	OUTCOME OR UPDATE
<b>FOR EXAMPLE: STUDENT'S CAREER GOAL IS TO BECOME A CHEF</b>	<b>STUDENT, PROGRAM COORDINATOR, POSSIBLY PARENT FOR TRANSPORTATION</b>	<b>JOB SHADOWING</b>	<b>FALL SEMESTER 20__</b>	DECEMBER __, 20__ (LAST MEETING BEFORE WINTER BREAK)	<b>STUDENT JOB SHADOWED AT OLIVE GARDEN DURING DMD IN OCTOBER, 20__</b>
<b>1.</b> _____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____
<b>2.</b> _____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____

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FLORIDA HIGH SCHOOL HIGH TECH PROGRAM  
GOODWILL INDUSTRIES OF SOUTHWEST FLORIDA, INC.

**D**ISCHARGE **S**UMMARY

Student's Name: \_\_\_\_\_ Conference Date: \_\_\_\_\_

**DISCHARGE SUMMARY:** Dates of Service: From \_\_\_\_\_ to \_\_\_\_\_ ETO \_\_\_\_\_

Date of Discharge: \_\_\_\_\_ Reason for Discharge:  Voluntary  Involuntary

Did participant successfully complete the program?  Yes  No If no, explain: \_\_\_\_\_

Was consumer given a Consumer Satisfaction Survey?  Yes  No If no, explain: \_\_\_\_\_

**Please check any that apply for reasons to discharge consumer:**

Moved away  No longer interested  Not able to contact for services after repeated attempts

Non-Compliant  Medical Reasons  Indefinitely ON HOLD for personal reasons

OTHER \_\_\_\_\_

Student Signature: (if available) \_\_\_\_\_ Date: \_\_\_\_\_

FL HSHT Coordinator's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

cc:

\_\_\_\_ Student

\_\_\_\_ Parent / Guardian

\_\_\_\_ Copy to file

\_\_\_\_ Other \_\_\_\_\_