KIM BROWN-ANDERSON
KCP

AVIATION CAREER EDUCATION (ACE) ACADEMY

Application Form
(Please type or print in ink)

Name_____
(Last) (First)

Address_____
(Street)

_____
(City) (State) (ZIP)

Home Phone_____ Birth Date_____

Name of Parent/Guardian _____

Work Phone _____ Emergency Phone _____

Name of current middle/high school_____

Grade in school_____ Age_____

Optional Information:

Male_____ Female_____

Ethnic Background (**Please check √ only one**)

1)____American Indian/Alaskan Native 2)____Asian/Pacific Islander
3)____Black (Other than Hispanic 4)_____Hispanic
5)____White (Other than Hispanic 6)_____Other

1) List the school activities, clubs, organizations or sports teams in which you participated during this school year.

2) Why would you like to attend the ACE Academy, and how do you think it will benefit you? Please write a brief paragraph in the space provided.

3) Please submit a letter of recommendation from one of your teachers.

(Applicant's Signature) (Date)

(Parent/Guardian Signature) (Date)

QUALIFICATIONS/REQUIREMENTS

Admission to the ACE Academy is both competitive and selective. Applications **must be complete, including the medical consent form**. Complete applications should be returned KCP office by mail or fax to (577-8011 Fax) 906 W. Warren 345 Manoogian Hall Detroit, MI 48202 on or before **Friday, June 23, 2006** to be considered.

Please provide us with a copy of this applicant's most recent grades/progress reports. Transcript should accompany the application package.

For further information contact:
William Robinson, Jr., 577-3085, FAX: 577-8011

MEDICAL RELEASE FORM

ACE Academy Administrator:

In the event that _____needs medical care during his/her official participation in the **Wayne State University ACE Academy,** you have my permission to arrange for medical treatment when necessary and performed by a licensed qualified physician. (Parent/guardian to be notified in case of emergency.)

Student Name_____

Address_____

Date of Birth: (Month)_____(Day)_____(Year)_____

Home Phone No._____Parent/Guardian Work No._____

Medical/Health Insurance Company_____

I.D.#, Group/Contract#, Benefit#_____

Does student have allergies to medication or other important medical factors?
_____Yes _____NO

If yes, please explain_____

_____

_____

Prescribed medication/condition or physical handicap_____

_____

_____

Person other than parent/guardian to be contacted in case of emergency:

Name_____Phone_____

_____ _____

Parent/Guardian Signature **Date**