



CRANDALL PIRATES SPORTS MEDICINE APPLICATION

APPLICATION DUE: _____

STUDENT INFORMATION (Please PRINT legibly):

Name: _____ ID# _____ Grade: ____ Current School: _____

Address: _____ City: _____ Zip: _____ DOB: _____

Student School Email: _____ Student Cell #: _____

Mom/Dad/Guardian name: _____

Mom/Guardian email address: _____ Cell #: _____

Dad/Guardian email address: _____ Cell #: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Write a brief essay on why you want to be in the Sports Medicine Program (use the back if necessary):

What recognition and awards have you earned (Honor Society, Service Awards, etc.):

What are you plans after you graduate from high school?

List some job/career choices of interest:

What other extracurricular activities are you involved in?: _____

*Please note: the time commitment for Athletic Training is the same, if not more, than what is required for a sport. Please take that into consideration when applying for the Sports Medicine program.

Will you be able to attend before and/or after school practices and games?: YES NO

Do you plan on having a job while being a Student Athletic Trainer?: YES NO

If yes, would you be willing to schedule around Athletic Training duties?: YES NO



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ACADEMICS:

- ⚡ **APPLICANTS MUST BE IN GOOD ACADEMIC STANDINGS. PLEASE ATTACH A COPY OF YOUR SKYWARD REPORT CARD CONTAINING GRADES FOR THE ENTIRE CURRENT SCHOOL YEAR. PLEASE MAKE SURE YOUR GRADE REPORT INCLUDES ALL GRADES FOR BOTH PROGRESS AND 6 WEEKS REPORTING PERIODS. APPLICATIONS SUBMITTED WITHOUT A GRADE REPORT WILL BE AUTOMATICALLY VOIDED.**

REFERENCES:

- ⚡ **3 RECOMMENDATION FORMS MUST BE RETURNED TO THE ATHLETIC TRAINING STAFF FOR CONSIDERATION**
 - PRINT AND GIVE A "RECOMMENDATION FORM" TO 3 DIFFERENT TEACHERS, COACHES, PRINCIPALS, OR COUNSELORS TO FILL OUT AND RETURN VIA *SCHOOL INTEROFFICE MAIL*
 - PROVIDE AN ENVELOPE WITH EACH RECOMMENDATION FORM WITH THE FOLLOWING INFORMATION PRINTED ON THE FRONT (NO STAMP REQUIRED)
 - **ATTENTION: MARY LYNN MILLER, ATC, LAT, Coordinator of Sports Medicine**
 - **DEPARTMENT: ATHLETICS**
 - **CAMPUS: ATHLETIC TRAINING ROOM**
 - THESE FORMS ARE TO BE SENT BACK BY THE REFERENCE, NOT BY THE APPLICANT.
- ⚡ **PLEASE LIST THE NAMES, DEPARTMENTS, AND SCHOOLS OF THE 3 REFERENCES YOU WILL BE GIVING FORMS TO:**

<i>NAME:</i>	<i>DEPARTMENT:</i>	<i>SCHOOL:</i>
1:		
2:		
3:		

IMPORTANT NOTES:

- ⚡ **If accepted into the sports medicine program:**
 - you will be required to follow a specific dress code
 - you will be required to maintain a 70% or higher grade in all classes
 - you will be required to attend tutorials if your grades fall below a 70% in any class
 - you will be required to work some holidays and weekends throughout the school year
 - you understand that the time commitment for Athletic Training is the same, if not more, than what is required for a sport
 - you will be required to work with a sport each semester throughout the school year
 - Please contact Mary Lynn Miller, ATC, LAT with any further questions or concerns about applying for the Sports Medicine Program.

PARENT/STUDENT CONSENT:

I _____ understand that I must maintain at least a 70% in all course work attempted. I understand that a Student Athletic Trainer's role requires a major time commitment, if not more, than playing a sport. I understand that as a Student Athletic Trainer, I am making a commitment to an extra-curricular program and must assume a responsible role in the daily duties, must abide by the school and program dress code, and be on time to all events, practices, and meetings. Any violation or conduct unbecoming may result in immediate dismissal from the program. *I also understand that an incomplete application will be automatically voided.*

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Please complete and return this application with a copy of your skyward report card to:

*Mary Lynn Miller, ATC, LAT, Coord. Of Sports Medicine
mmiller@crandall-isd.net Office: 972-427-6000 ext. 5676*



CRANDALL PIRATES SPORTS MEDICINE RECOMMENDATION FORM

Student: _____ ID # _____

To the teacher: This student is applying for the Athletic Training Program and is required to submit recommendations to complete their application. Please evaluate the student and return this form to Mary Lynn Miller, ATC, LAT, Coordinator of Sports Medicine. This is a confidential report and should be returned by you through inter-office mail and not given back to the student to return. At no time will the student be allowed to view this evaluation. Thank you for your professional assessment.

Please evaluate the following citizenship/character traits of the above named student:

	Outstanding	Good	Fair	Poor
Dependability				
Honest/integrity				
Confidentiality				
Ability to follow instructions				
Follows rules				
Attitude				
Maturity				
Personal grooming				
Punctuality				
Cooperation with others				
Verbal communication				
Writing skills				
Sets realistic goals				
Problem-solving skills				
Self-Motivation				

Do you have any reservations about this student participating in a medically-based program? Please comment:

Teacher name: _____ Class: _____ School _____

Teacher Signature: _____ Date: _____

☛ Please complete and return via Inter-office mail in the envelope provided by applicant as soon as possible to:

*Mary Lynn Miller, ATC, LAT
Dept: Athletics
Campus: Athletic Training Room*



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