The B.E.S.T. BRAIN EXPANSIONS SCHOLASTIC TRAINING

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March 15, 2010

Dear Parents, Principals and Educators:

We would like to make you aware that we have a very exciting summer program plan for students in the Tampa Bay Area. We are now accepting applications for review. If your child or student has expressed being a health professional one day this program may be for them. This Program focuses on exposing, engaging, and enriching middle school and high school students in health care careers, while enhancing their academics using memory skill using brain based games. The program's primary goal is to ignite interest and provide exposure in the fields of science technology and health.

Participants of the B.E.S.T. Program will be given educational projects related to the healthcare needs of minority and underserved populations while receiving guidance from professionals and college level students who have skills and knowledge of the needs of special populations.

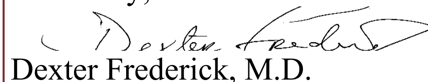
Students who are selected to be part of the B.E.S.T. Program will be eligible for the following:

1. Personalized intense tutoring on verbal content
2. Personalized memory preparation training to enhance their long-term retention and decrease studying time
3. Personalized College Readiness based on career interest
4. Personalized PSAT/SAT/ACT Preparation; B.E.S.T. has formed partnership with KAPLAN and they will now sponsor most of our preparation and enrichment.
5. Creative and community hours needed for High School Graduation Requirement
6. Summer Internship Programs at health facilities - automatic acceptance
7. College Scholarships after completion of the B.E.S.T. Program.
8. A Letter of Commendation to any college or employment needed

Your child needs your help to fill out the B.E.S.T. Application before being accepted officially into the B.E.S.T. Program. Once accepted they will be reviewed and you will be told of the decision.

If you have any questions regarding the B.E.S.T. Program or the application process please contact me at 813-892-2182 or via email at brainexpansions@yahoo.com.

Gratefully,



Dexter Frederick, M.D.

AHEC GULFCOAST NORTH AREA HEALTH EDUCATION CENTER
Florida Medical Clinic Foundation OF CARING
USF HEALTH

Brain Expansions Scholastic Training.

B.E.S.T. Summer Medical Academy Dates: Monday June 21, 2010-Friday, July 30, 2010

B.E.S.T. Summer Medical Academy Location: HOPE CENTER

B.E.S.T. Summer Medical Academy Eligibility Criteria:

A minimum 3.3 cumulative grade point average and student motivated to enter a health career. (*Note: Program Staff will verify the G.P.A of all Applicants).

Must be 9th-12th Grade Under-represented Student(Note: 8th Graders entering 9th Grade areeligible to apply. Students that will be graduating at the end of the 2009-2010 academic school year with a High School Diploma are not eligible to apply).

Submit an official high school transcript.

Submit two (2) letters of recommendation (community sources, teachers)

Must write a full one page typed essay detailing a specific health career pursuit/personal goal in nursing, pharmacy, physical therapy, medicine, etc

B.E.S.T. Summer Medical Academy Curriculum: Curriculum will accomplish the following:

- Expose students to a variety of health careers with concentration on their personal health career choice.
- Proficiency in basic anatomy and physiology of certain body systems
- Familiarize student with local colleges and universities (USF, UT, USF College of Med)
- Expose students to a practical health care setting at Clinics or Hospital
- Develop and implement a personalized learning experience that will assist students for life
- Teach a memory training program that seeks to enhance long-term retention and decrease studying time
- Develop skills and receive certification in First Aid and CPR.
- Create a health care mentor program with community health care professionals
- Development of appropriate behavior and professional/social

B.E.S.T. Summer Medical Academy Application Process

1. Applications must be received by Friday May 7th, 2010
2. Submit application in person or mail to
   Ms. Mary Freeny, BEST Program Coordinator
   10006 Cross Creek Blvd Box 406
   Tampa, FL 33647

B.E.S.T. Summer Medical Academy Selection Process

1. Applications will be judged by 3 reviewer from the B.E.S.T. Program/Board of Directors
2. Applicants will be notified by phone, mail or email by May 31st, 2010 regarding the status of his/her acceptance

B.E.S.T. Summer Medical Academy Program Fee: Fees will be discussed after acceptance

This fee will cover the following:

1. Curriculum Material, Program Materials, T-shirts, Identification Cards, Meals on Tours, Instructional Cost, Insurance Coverage, Guest Speakers

BRAIN EXPANSIONS SCHOLASTIC TRAINING (B.E.S.T.)
2009 – 2010 APPLICATION

New Student ☐ **Returning Student** ☐ **Summer Student** ☐

All Completed applications should be returned to the B.E.S.T. Site Coordinator at each school.
Please type or print legibly.

Student Demographic Information:

Name: ____
Last First Middle

Mailing Address: ____

City: ______________________ State: ____________ Zip Code: ____________

Email Address: ______________________ Student ID #: ____________

Home Number: (_____)____________ Date of Birth: _____-_____-________ Sex: Male ☐ Female ☐
MM DD YYYY

Ethnicity (Please check one):
☐ Asian
☐ Pacific Islander
☐ American Indian/Alaskan Native
☐ Other ______________
☐ African-American/Black (Non-Hispanic)
☐ Hispanic
☐ White (Non-Hispanic)

Parent/Guardian Information:

I currently live with: ☐Mother ☐Father ☐Both ☐Guardian(s) ☐Other

Mother or Legal Guardian:

Name ______________________

Place of Work: ______________________

Home Number (______)______________________

Cell Number (______)______________________

Work Number (______)______________________

Father or Legal Guardian:

Name ______________________

Place of Work: ______________________

Home Number (______)______________________

Cell Number (______)______________________

Work Number (______)______________________

Is either parent or guardian a graduate of a 4-year college or university? Yes ☐ No ☐

Is either parent or guardian a graduate of a 2-year college, junior college, or technical school? Yes ☐ No ☐

Do you have any family members working in the health professions? Yes ☐ No ☐
If yes, please describe the health profession.______________________________

If you enroll in college, will you become the first member of your immediate family to attend college? Yes ☐ No ☐

Do you participate in the federally funded free/reduced lunch program at your school? Yes ☐ No ☐

Student Education Information:

☐ Elementary School ☐ Middle School ☐ High School

Name of Current School: ____ Grade: ___________

If available, please provide:
FCAT Reading Score: ________ FCAT Math Score: ________ Grade Point Average: ________
PSAT Total Score:________ SAT Total Score: ________ ACT Total Score: ________
(All applications must include a copy of your last report card or student permanent record)

Future Career Plans:
In the future I want to attend a: ☐ Community, Technical, or Junior College ☐ 4-year College/University
When I grow up I want to be a: (1) ____ **or**
(2) ____ **or**
(3) ____

Completed application packets (including: application, student/parent statement, sealed recommendation form, and last report card or student transcript) must be submitted by the student applicant or parent to the B.E.S.T Coordinator at each school. Or you can mail your application to:

Dexter Frederick, M.D., Executive Director
10006 Cross Creek Blvd.
Tampa, FL 33647
Fax: 813-889-9566
Email: brainexpansions@yahoo.com

PRIVACY ACT

I understand that the information concerning me, my spouse and child as a client will be kept in confidence and will not be revealed to anyone except to **B.E.S.T.** personnel in accordance with the Family Educational Rights and Privacy Act.

SIGNATURE AUTHORIZATION FORM

If selected as a B.E.S.T. Program participant, we agree to adhere to the rules, guidelines, and policies of the B.E.S.T. Program and its staff. Any failure to obey the aforementioned rules may result in my child's immediate dismissal from the program.

I agree that in exchange for the value of the benefits my son/daughter/ward will receive in this Program, the Program has the right (without provision of compensation) to record his/her participation, appearance, image, likeness, and voice on videotape, audiotape, film, photograph or in any other medium and to publish the same in any form (such as print, electronic video, or internet) only for the purpose of inclusion in Program promotional materials.
I am also willing to have my child participate in activities that involve check vital signs(Blood Pressure, Heart Rate, Respiratory Rate, Temperature and Weight)

Student's Signature ____ Date _____________

Parent's or Guardian's Signature ____________________________________ Date ______________

Parent's or Guardian's Signature ____________________________________ Date ______________
(Only one parent/guardian signature is required)

The Brain Expansions Scholastic Training – B.E.S.T. Program
Student and Parent Statement

Students Only: The B.E.S.T. Program provides opportunities for middle and high school students to learn about the possibilities available in the health professions, introduce them to the requirements for college, and equip them with the tools, information and resources they need to be successful. In a few sentences please explain how your participation in the B.E.S.T. Program will help you with your future career goals. Attach additional sheets if necessary.

Parents Only: In a few sentences please describe your expectations of the B.E.S.T. Program and ways in which you can benefit from your child's participation in the program. Attach additional sheets if necessary.

TEACHER/COUNSELOR RECOMMENDATION FORM FOR THE B.E.S.T. PROGRAM

Recommender's Name: ____

(The recommender must be a current teacher or student counselor)

Name of Applicant: ____

Name of subject you taught applicant and grade level: ______________________________

PART II – TEACHER RECOMMENDATION

1. To your knowledge, does this student have a history of disciplinary problems? Yes ☐ No ☐
   If yes, please explain. ____
   ____
   ____

3. Has the student been recognized for outstanding academics, leadership, or community service?
   ____
   ____

4. Based upon your professional opinion, please rate the applicant according to the scale below:
   (Place an X in the appropriate category.)

1=POOR 2=AVERAGE 3=ABOVE AVERAGE 4=EXCELLENT

Attribute	1	2	3	4	Not Observed or Not Applicable
Interested in learning					
Motivation					
Maturity					
Self-discipline					
Reliability					
Initiative					
Leadership					
Ability to work with peers					
Emotional Stability					
Overall Evaluation					

Additional Comments: ____
____
____

______________________________________ ________________

Teacher/Counselor Signature **Date**

Thank you for completing this recommendation for the Brain Expansions Scholastic Training Program (B.E.S.T.). Please return this form to the applicant in a sealed envelope with your signature over the seal. **All completed applications require a teacher/counselor recommendation form.**

CONSENT FORMS FOR THE B.E.S.T. PROGRAM

Emergency Medical Treatment

In case of emergency, I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event that I cannot be reached, I hereby give my permission to the licensed health care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if an adult).

____

Signature of parent/ guardian

Check all items that apply, past or present, to your health history. Explain any "Yes" answers.

ALLERGIES: Food, plants, medicines, insect bites Yes ☐ No ☐

Explain:____

GENERAL INFORMATION

	Yes	No
Asthma	☐	☐
Cancer/ Leukemia	☐	☐
Convulsions/ Seizures	☐	☐

Explain Other:____

List any medications to be taken at program____

List any physical or behavioral conditions that may affect or limit full participation in swimming, hiking long distances, or playing strenuous physical games_________________ ____

List equipment needed such as wheelchair, braces, glasses, contact lenses, etc.________________________

Immunizations Up to Date: **Yes** ☐ **No** ☐

Family Doctor: ___________________________________ Phone: _________________________________

Address: _______________________________ City: _________________Zip: _____________________

In case parent/guardian cannot be reached in an emergency, please contact:

Name: ______________________________Relationship: _____________Phone Number: ___________

I HAVE READ, UNDERSTOOD, AND AGREED TO ALL OF THE ABOVE.

____ __________________

Name of parent/guardian (Please print) Date

____

Parent/Guardian's Signature

AUTHORIZATION TO RELEASE SCHOOL RECORDS B.E.S.T. PROGRAM

PARENT/GUARDIAN CONSENT

Student Name: ____

Date of Birth: ____

I, the parent or guardian of the above-named student, hereby authorizes

____

Student School's Name

I, the parent or guardian of the above-named student, hereby authorizes to release information from my child's scholastic record, which also includes any transcripts, class schedules, attendance records, scores for standardized achievement, diagnostic test/assessments, special education records to the **B.E.S.T. Program**. I hereby grant permission for the **B.E.S.T. Program** to use these records for only internal use during the aforementioned program. Use of information will only be used for assessing student need, statistical purposes and program evaluation. This information will be kept confidential

I HAVE READ, UNDERSTOOD, AND AGREED TO ALL OF THE ABOVE.

Parent/Guardian's Name: ____

(Please print)

Parent/Guardian's Signature: ____

Primary Phone: ________________________________ **Date:** ______________________________________