



Summer School Application & Registration

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Please fill out & return this page to the Grauer School to apply for Summer School. The student contract, medical release form, and payment must be completed prior to the start of class.

Name: _____

Home Address: _____

City/Zip: _____

Date of Birth: _____

Home Phone: _____

School Last Attended: _____

Grade Completed: _____

Name of Parent 1: _____

Work Phone: _____

Cell Phone: _____

Name of Parent 2: _____

Work Phone: _____

Cell Phone: _____

Parent Email: _____

Student Email: _____

Parent Signature*

Date

*Signature constitutes an agreement for full payment of services prior to the start of class. The student must fill out a Medical Release form & a Student Contract (both will be in effect during this program) on or before the first day of class — students will not receive academic units until all forms are complete. Your signature gives us permission to treat your child medically if we deem it appropriate.

Course Information

Course: _____

Details: _____

Payment/Fees Due

Course(s) Tuition: _____

Other Fees: _____

*3% charge will be applied for all credit card payments.

Total Payment for course(s): _____

Payment Method/Details: _____

Signed,

Student

date

Parent or Guardian*

date

Administrator

date

*Signature constitutes an agreement for full payment of services prior to the start of class. The student must fill out a Medical Release form & a Student Contract (both will be in effect during this program) on or before the first day of class — students will not receive academic units until all forms are complete.



The Grauer School

STUDENT APPLICATION-MEDICAL FORM

_____		_____	
Student's last name	_____	First name	_____
_____		_____	
Parent or Guardian	_____	Parent or Guardian	_____
Street Address (home) _____			
_____		_____	
City, State	_____	Zip	_____
_____	_____	_____	_____
home phone	cell phone	work phone	
Emergency contact other than parent:			
Name: _____		Relationship: _____	
Street Address (home) _____			
_____		_____	
City, State	_____	Zip	_____
_____	_____	_____	_____
home phone	work phone		
Name Student insurance comp.		policy number	
_____		_____	
family physician	phone #		
_____	_____		
Date of Birth	Height	Weight	
_____	_____	_____	

Check all applicable conditions of Student:

- _____ allergies (general, food, medical, drug, etc.)
- _____ allergy to bee stings
- _____ asthma
- _____ back aches or weak back
- _____ bowel or bladder problems
- _____ car/sea sickness
- _____ epilepsy or convulsive disorder
- _____ hay fever or sinus trouble
- _____ headache
- _____ heart trouble or murmur
- _____ poison oak
- _____ respiratory problems
- _____ sleep walking
- _____ vomiting
- _____ other: _____

Explain items checked above: _____

Submit copy of medical or accident insurance card

EMERGENCY INFORMATION

Name of student's medical/accident insurance company: _____ policy # _____

In an emergency, which parent should be contacted first? Mother? ___ Father? ___ Other? ___

In an emergency, we authorize the school to release the student to:

1st Choice. Name:

Address _____ Phone _____ Relationship _____

2nd Choice. Name:

Address _____ Phone _____ Relationship _____

Student's Doctor: _____ Phone _____

Any special infirmities of which we should be aware? _____

If your child is seriously ill or injured and you cannot be contacted:

- | | | |
|---|------------------------------|-----------------------------|
| May he/she be taken to your doctor? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| May he/she be taken to the nearest hospital? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| May an ambulance/paramedic unit be called? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| May the family doctor or hospital give emergency treatment? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| May he/she be given aspirin? Tylenol? Ibuprofen? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Date of last tetanus shot _____

Is he/she taking medication on a regular basis? ___ If so, which? _____

Is Student on any medication? YES NO DESCRIBE: _____

Instructions for administration of medication: _____

This medication taken for (state med. condition and ANY risks/limitations): _____

Disclosure 1: Has your child ever been diagnosed with ADD, learning differences, special education needs, Dyslexia, etc.? yes no Explain on back

Disclosure 2: Does your child have a current diagnosis of any communicable disease? yes no Explain on back or submit a sealed envelope with this form.

7th Grade Applicants only (except w/personal-belief exemption):

- Have you included documentation of hepatitis B immunization (use blue California School Immunization Record) (California AB 381)? No Yes
- Have you included documentation of second dose of measles-containing vaccine (such as MMR) (California 1999)? No Yes
- Has your doctor screened your child for scoliosis? No Yes

Check those non-prescription medications we may have permission to give Student under the supervision of an adult, group leader or teacher (generic equivalent of such medication may be used):

Yes	No	
_____	_____	Kaopectate or similar (for diarrhea)
_____	_____	Pepto Bismol (for upset stomach)
_____	_____	Milk of Magnesia (for constipation)
_____	_____	Chloraseptic spray (for sore throat)
_____	_____	Caladryl (for skin rashes or insect bites)
_____	_____	Hydrocortisone (for skin rashes or insect bites)
_____	_____	Acetaminophen/Aspirin/Ibuprofen (e.g., Tylenol/Bayer/Advil for headache, pain, elevated temperature)

Parent: Have you submitted copy of student accident insurance card or first page of policy? No Yes
If not, state reason:

My signature below signifies that this health history is correct so far as I know, that the student has **current medical insurance**, and that Student named on this form has permission to engage in all school activities except as noted. I hereby give permission to outdoor education officials and teachers to:

1. Provide ongoing health care; and
2. Select medical personnel, to order x-rays, routine tests or secure treatment for the Student named on this form.

Is Student capable of participating in a strenuous hike in which the pace is set by his/her peers? YES NO

PARENTAL AUTHORIZATION

I do voluntarily consent to participation by Student, a minor, in educational program(s) conducted inside and outside The Grauer School (the "School"). The undersigned releases, holds harmless and agrees to indemnify the School, including its teachers, administrators, officers, agents and employees, from any claims or damages of any kind and hereby assumes all risk of loss and harm that may be incurred, directly or indirectly, as a result of Student participation in all activities of the School (INCLUDING DAMAGES CAUSED BY NEGLIGENCE OF THE SCHOOL OR BY ANY OTHER STUDENT OR A TEACHER, ADMINISTRATOR, OFFICER, AGENT OR EMPLOYEE) including, but not limited to, field trips and transportation by private automobile, and whether occurring on or off the campus and during or outside of class hours. I also authorize school officials to arrange for professional care and treatment in case of medical emergency; this authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California. I hereby give my permission to the physician, dentist or professional selected by field trip organizers or representatives to hospitalize, secure proper treatment for, and to order injections and/or anesthesia and/or surgery for the Student named on this form. A photocopy or facsimile of this authorization is as valid as the original.

I understand that all medical/accident expenses are the sole responsibility of parents/guardians and their respective insurance companies. I further agree to direct Student to comply with the policies of the School and field trip organizers and their personnel. I realize that if Student does not comply with said practice, he/she may be sent home from the facility or expedition at my, the parent or legal guardian's, expense.

DATE _____ SIGNATURE _____

