

***“A Catholic Education an Advantage for life”***

**OUR LADY OF VICTORY CATHOLIC SCHOOL**

601 E. Palmer St., Compton, CA 90221  
Tel. (310) 631-1320 Fax (310) 631-4280  
Ourladyofvictorycatholicsschool.org

**Summer Academic School Application**

**Student’s Name/ Nombre de Estudiante**

_____	Birthdate _____
Last	First
_____	Birthdate _____
Last	First
_____	Birthdate _____
Last	First

**Contact Information / Información de Padres**

Mother/Guardian’s Name \_\_\_\_\_

Cell # (\_\_\_\_) \_\_\_\_\_ Home phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

Employer \_\_\_\_\_ Hours from \_\_\_\_\_ to \_\_\_\_\_

Father Guardian’s Name \_\_\_\_\_

Cell# (\_\_\_\_) \_\_\_\_\_ Home phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

Employer \_\_\_\_\_ Hours from \_\_\_\_\_ to \_\_\_\_\_

**Emergency Contact / Contacto de Emergencia**

1) \_\_\_\_\_ Relationship: \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Name

2) \_\_\_\_\_ Relationship: \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Name

## Student/Provider Contract - Contrato Estudiantil

I, \_\_\_\_\_, a student in the Summer Academic Program promise to participate and work to my best ability, behave myself, and show respect towards my classmates as well as the staff here at Summer Academic Program.

**Student signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## Student/Provider Contract - Contrato Estudiantil

I, \_\_\_\_\_, a student in the Summer Academic Program promise to participate and work to my best ability, behave myself, and show respect towards my classmates as well as the staff here at Summer Academic Program.

**Student signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## Student/Provider Contract - Contrato Estudiantil

I, \_\_\_\_\_, a student in the Summer Academic Program promise to participate and work to my best ability, behave myself, and show respect towards my classmates as well as the staff here at Summer Academic Program.

**Student signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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## Consent for Picture taking form - Permiso de Retratar

I, \_\_\_\_\_, hereby give permission to the staff of the Summer Academic Program to take pictures of my child(ren), \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ to be displayed on the Our Lady of Victory School website and media account, or by other media sources, and to retain for historic purposes. I am aware I can revoke my consent by sending a letter in writing to the site director.

\_\_\_\_\_  
**Signature of Parent or Guardian** **Date** \_\_\_\_\_

\*\*\*\*\*

## Refuse Consent for Picture taking form

I, \_\_\_\_\_, Do Not Give Permission to the staff of the Summer Academic Program to take pictures of my child (ren) \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
**Signature of Parent or Guardian** **Date** \_\_\_\_\_

## MEDICAL RECORD - Información Medico

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_\_

Mother/Guardian's Name \_\_\_\_\_

Address \_\_\_\_\_

Cell / Home Phone number (\_\_\_\_) \_\_\_\_\_ Work Phone Number (\_\_\_\_) \_\_\_\_\_

Father/Guardian's Name \_\_\_\_\_

Address \_\_\_\_\_

Cell / Home Phone number (\_\_\_\_) \_\_\_\_\_ Work Phone Number (\_\_\_\_) \_\_\_\_\_

Physician's Name \_\_\_\_\_

Address \_\_\_\_\_

Phone number (\_\_\_\_) \_\_\_\_\_

**Insurance Information - Aseguranza**

Child's Name: \_\_\_\_\_

Child's Medical Record Number \_\_\_\_\_

Chronic Illnesses/Allergies/ Current Medications \_\_\_\_\_

Special information: \_\_\_\_\_

**Insurance Information - Aseguranza**

Child's Name: \_\_\_\_\_

Child's Medical Record Number \_\_\_\_\_

Chronic Illnesses/Allergies/ Current Medications \_\_\_\_\_

Special information: \_\_\_\_\_

**Insurance Information - Aseguranza**

Child's Name: \_\_\_\_\_

Child's Medical Record Number \_\_\_\_\_

Chronic Illnesses/Allergies/ Current Medications \_\_\_\_\_

Special information: \_\_\_\_\_

**EMERGENCY MEDICAL CONSENT FORM - Permiso de Proveer Atención Médica**

The Summer Academic Program has my permission to obtain emergency medical treatment for my child when I cannot be reached or if a delay in reaching my child would be dangerous for him/her.

My insurance provider is \_\_\_\_\_

My child's name: \_\_\_\_\_

My child's medical record number is \_\_\_\_\_

Preferred hospital/treatment center \_\_\_\_\_

My child has the following medications \_\_\_\_\_ , \_\_\_\_\_ , \_\_\_\_\_

My child has the following allergies \_\_\_\_\_ , \_\_\_\_\_ , \_\_\_\_\_

I understand that I assume all financial responsibility for any treatment or injuries sustained by my child while he/she is in the Summer program

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

