

# Delphi Academy™ of Los Angeles Summer Camp 2017

*For a great summer of fun  
and learning!*

## **SUMMER PROGRAM ENROLLMENT PROCEDURES**

This form needs to be filled out completely, signed and submitted along with the Summer Program Application.



Please affix  
a photo of  
your child  
here.

## Delphi Academy of Los Angeles Summer Program Enrollment Terms

In the best interest of the Delphi Academy Summer Program and my/our child \_\_\_\_\_(name), the undersigned parent(s) and/or legal guardian of the student agrees to the following:

### Consent to medical care for student

I/We consent to any X-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care to be rendered to the student at my/our expense upon the advice and under the general or special supervision of a physician, surgeon and/or dentist licensed under the provisions of applicable medical practice laws.

I/We give my/our permission for the student to participate in the following activities that may have some inherent risk. I understand that neither Delphi Schools, Inc., the Delphi Academy nor any of its employees, students or volunteers shall be liable to myself or to my child for any claim arising out of these activities, such claims being hereby waived, and that I will indemnify and save harmless Delphi Schools, Inc., Delphi Academy and its employees, students and volunteers from all liability for claims as well as from claims of all other persons resulting from any act of my/our child during these activities:

- a. swimming and sports
- b. classes and activities
- c. field trips, outings, students riding in school buses

I/We assume responsibility for any acts of my/our child during any field trip or school outing, and will indemnify (reimburse or repay for any loss incurred) and hold the foundation, school, its employees and volunteers harmless from any claims of any person arising from my/our child's acts. "Field trip or outing" includes period of travel time to and from the school.

I/We and my/our child agree to support the school by adhering to procedures and rules set forth in the "Delphi Student and Parent Handbook." (The "Delphi Student and Parent Handbook" is available online.)

I/We understand that Delphi has the right to refuse any applicant or to dismiss any student misrepresented during enrollment or whose conduct or influence is unsatisfactory or is, in the opinion of the school, not in the best interest of the Delphi Academy of Los Angeles Summer Program.

I/We understand that the school has access to all belongings at any time for the purpose of inspection.

I/We understand that students are responsible for their belongings.

### Publications:

I/We hereby give my/our permission to Delphi Schools, Inc. and/or Delphi Academy of Los Angeles to use pictures of the student or to use written material, in whole or in part, or to summarize the contents of the material written by the student in promotional materials of the school.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

# MEDICAL HISTORY, CONFIDENTIAL HEALTH REPORT AND GENERAL INFORMATION FORM

To be filled out by parent or legal guardian

NAME OF STUDENT: \_\_\_\_\_

SEX: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

HAS STUDENT HAD ANY OF THE FOLLOWING (check yes or no) : If yes has been marked on any of the following items please explain on a separate piece of paper and attach to this form.

Yes	No	Year		Yes	No	Year	
___	___	___	appendicitis	___	___	___	asthma, hay fever, allergies
___	___	___	chronic cough	___	___	___	pain or pressure of chest
___	___	___	thyroid trouble	___	___	___	frequent indigestion
___	___	___	hernia (rupture)	___	___	___	arthritis, rheumatism
___	___	___	foot trouble	___	___	___	pneumonia
___	___	___	epilepsy/convulsion	___	___	___	pleurisy
___	___	___	eye trouble	___	___	___	cramps in legs
___	___	___	ear trouble	___	___	___	swollen or painful joints
___	___	___	throat trouble	___	___	___	tumor or cyst
___	___	___	nose trouble	___	___	___	bone infection
___	___	___	frequent colds	___	___	___	nervous disorder
___	___	___	sinus trouble	___	___	___	pile or rectal disease
___	___	___	bone/joint deformity	___	___	___	kidney or bladder disease
___	___	___	stiffness of joints	___	___	___	frequent headaches
___	___	___	heart disorders	___	___	___	dizziness or fainting spells
___	___	___	stomach trouble	___	___	___	jaundice
___	___	___	severe tooth trouble	___	___	___	hearing impairment
___	___	___	speech difficulties	___	___	___	tonsillitis
___	___	___	strep throat	___	___	___	frequent nausea/vomiting
___	___	___	frequent nose bleeds	___	___	___	fracture/broken bones
___	___	___	diabetes	___	___	___	surgery or operations

## INFECTIOUS DISEASE HISTORY:

Yes	No	Year		Yes	No	Year	
___	___	___	Measles	___	___	___	Typhoid
___	___	___	Mumps	___	___	___	Diphtheria
___	___	___	Chickenpox	___	___	___	Malaria
___	___	___	German measles	___	___	___	Infectious mononucleosis
___	___	___	Poliomyelitis	___	___	___	Venereal disease
___	___	___	Rheumatic fever	___	___	___	Scarlet fever
___	___	___	Whooping cough	___	___	___	Meningitis
___	___	___	Tuberculosis	___	___	___	Hepatitis

**DELPHI ACADEMY OF LOS ANGELES SUMMER PROGRAM MEDICAL RELEASE FORM**

In the event that a medical or surgical emergency should occur while your child is attending Delphi it is imperative that we have parental authorization on file. Any hospital or medical institution requires parental permission to render the necessary care to a minor patient. Please note that this release must be signed.

In case of illness, accident or similar emergency, Delphi, or any authorized agent thereof, is authorized to seek and obtain medical care or treatment for my child, any may authorize any physician, hospital or medical institution to render the necessary care.

I, the undersigned parent/legal guardian (circle one), authorize any emergency medical or surgical treatment to be given to

(name of child) \_\_\_\_\_

(relationship) \_\_\_\_\_

Further, I guarantee coverage of costs for any such treatment rendered.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

**INSURANCE INFORMATION**

Is your child currently covered by any form of comprehensive health, medical, or accident insurance? If so:

Name of Company \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_  
City/State/Zip

Policy Number \_\_\_\_\_ Extent of Coverage \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_

Social Security Number \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Please enclose an insurance card or photocopy of it.

**CONFIDENTIAL HEALTH REPORT**

1. Does your child have any physical handicaps? If yes, please explain.
2. Is your child currently under medical treatment? If yes, please give reasons, medications prescribed and names and addresses of doctors rendering treatment.
3. Has your child ever been treated by a psychiatrist/psychologist? If yes, please indicate inclusive date of treatment, including names and addresses of physicians and type of treatment received.
4. Has your child ever attempted suicide? If so, please give details.
5. Has your child ever used marijuana, LSD, barbiturates, or used or been prescribed any other psychedelic or psychotropic drugs? If so, please give details.

**EMERGENCY PHONE NUMBERS:**

Mother \_\_\_\_\_  
Home Work Cell

Father \_\_\_\_\_  
Home Work Cell

In case of emergency and you can not be reached, who should we contact?

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Date of last dental check \_\_\_\_\_

Dental Health: Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

Date of last physical check by doctor \_\_\_\_\_

Physical Health: Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

I have answered the questions accurately and certify that no information has been withheld or misrepresented. I understand that discovery of substantial falsification or omissions can result in no acceptance or immediate dismissal.

The student is a normal child who is a safe companion for other children.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

**GENERAL INFORMATION FORM**

NAME OF STUDENT \_\_\_\_\_

Who may pick up your child from school at any time? List names below and relationship to child:

If parents are divorced, do you as the custodial parent, want the other parent to receive copies of student reports and program mailings? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please give name and address of the other parent:

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

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