

TERM 1: June 6–23, 2011 ♦ TERM 2: June 27–July 14, 2011 (Mon.–Thurs. except week of July 4, Tues.–Fri.)

**PLEASE PRINT and complete as indicated in each section.** Counselor: \_\_\_\_\_

*Note: Out of district students must attach a transcript to this form. It may be an unofficial transcript.*

Check only ONE:  I am taking Summer School for CIF eligibility. \_\_\_\_\_  
 I am taking Summer School for graduation requirements. \_\_\_\_\_  
CIF Eligibility (Athletic Director signature required)

Student ID #: 

0	0	0	0						
---	---	---	---	--	--	--	--	--	--

 OJUSD students, use your current ID number. Non OJUSD students leave blank.

**STUDENT INFORMATION**  
All students

Last Name	First Name	Middle Initial	Date of Birth	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; text-align: center;">M</td> <td style="width: 20px; text-align: center;">F</td> </tr> </table> Gender	M	F		
M	F							
<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; text-align: center;">9</td> <td style="width: 20px; text-align: center;">10</td> <td style="width: 20px; text-align: center;">11</td> <td style="width: 20px; text-align: center;">12</td> </tr> </table> Grade entering next year	9	10	11	12	School currently attending	School attending next year		
9	10	11	12					
Home Address		City	Zip Code					
( )		( )						
Student home phone		Student cell phone						

**EMERGENCY**  
New and out of district students

Mother's Name	Address	( )	( )	( )
		Business phone	Home phone	Cell phone
Father's Name	Address	( )	( )	( )
		Business phone	Home phone	Cell phone
Emergency Contact (other than parent)	Address	( )	( )	( )
		Business phone	Home phone	Cell phone

**HEALTH**  
New and out of district students

Name of physician	( )	Address
	Phone number	
Special health conditions	Allergies (food, medicine, other)	
Please indicate the name of the nearest hospital or clinic where you prefer that care be provided. Be advised that the school may not be able to transport your child to the preferred facility but to the nearest health facility in emergency situations.		
Hospital or Clinic	Health Insurance (name of company)	Policy number

I hereby authorize OJUSD, its faculty and staff to take whatever steps are deemed necessary for the health and welfare of the student submitting this registration. This authorizes the school to admit the student to any hospital selected by the attending doctor. In the event of an accident/emergency, the student may be taken to the nearest doctor and/or hospital for treatment and care.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

