

# California State University, Los Angeles

## Level I (High School) Summer Intensive Program

Health Careers Opportunity Program (HCOP)

c/o Department of Biology and Microbiology

5151 State University Drive

Los Angeles, CA 90032-8207

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### Application for Admission

#### Application Check List

- General Medical Information Form
- Consent to Release Information Form
- Parental Information Form
- Counselor Recommendation Form
- Teacher Recommendation Form
- High School Transcripts (most recent)

#### PERSONAL INFORMATION

NAME:

\_\_\_\_\_

Last

\_\_\_\_\_

First

\_\_\_\_\_

Middle

MAILING ADDRESS:

\_\_\_\_\_

Number & Street

\_\_\_\_\_

City

\_\_\_\_\_

State

\_\_\_\_\_

ZIP

( )

( )

( )

\_\_\_\_\_

Day/Work Phone

\_\_\_\_\_

Evening Phone

\_\_\_\_\_

Pager/Voicemail

\_\_\_\_\_

Social Security Number

\_\_\_\_\_

Birthplace (Country & State)

\_\_\_\_\_

Date of Birth (Month Day Year)

Are you a U.S. Citizen?

or a permanent resident of the U.S.?

Alien Registration Number: \_\_\_\_\_

\_\_\_\_\_

Country of citizenship if other than the U.S.

**Academic Information**

High School: \_\_\_\_\_

Circle Present Grade Level: 9 10 11 12

Person who gave you this application: \_\_\_\_\_

Please write your present class schedule so that we can contact you for an interview:

Period	Class	Room #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

GPA: \_\_\_\_\_

SAT and/or ACT score: \_\_\_\_\_

Give the name, address and phone number of someone (a relative or friend) who does not live with you but can be contacted in the event of an emergency. A telephone number is mandatory.

_____	_____	_____	_____
Name	Address	City	Zip Code
(_____) _____	_____		_____
Telephone Number	Relationship		

## ESSAY QUESTIONS

1. If you had the chance to have a conversation with anyone; (living or deceased), who would you talk with and what would you talk about?

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2. Name one book you have read completely, give the author's name, and briefly summarize the book.

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3. Tell us about one of your closest friends, at home or at school. What type of person is he/she and why do you think you are friends?

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4. Please list three things you like most about yourself, and three things you like least about yourself.

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5. What extra-curricular activities do you participate in, both in and out of school?

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6. Do you feel your grades in high school, so far, accurately reflect your work and your abilities? Please explain.

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7. What are your two (2) favorite subjects and why?

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8. What are your two (2) least favorite subjects and why?

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**CALIFORNIA STATE UNIVERSITY, LOS ANGELES  
HEALTH CAREERS OPPORTUNITY PROGRAM**

**GENERAL MEDICAL INFORMATION**

**To be filled out by applicant's parents/guardian:**

Please complete the following in order that the doctor and nurse who will be treating your son/daughter may have as much information as possible in case he/she needs medical help for an illness or injury while attending our program.

Date: \_\_\_\_\_

Student's Name: \_\_\_\_\_  
Last First Middle

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_  
Street & Number City State ZIP

Telephone: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Home Phone Work Phone

Name of Parent or Guardian (or person to be notified in an emergency):

Name: \_\_\_\_\_  
Last First MI

Telephone: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Home Phone Work Phone

Parent/Guardian Employer: \_\_\_\_\_

Parent/Guardian Occupation: \_\_\_\_\_

Do you have any health insurance?  Yes  No

If yes, name of the insurance plan & telephone number:

\_\_\_\_\_

Do you belong to a clinic?  Yes  No

If yes, name of the clinic & telephone number:

\_\_\_\_\_

Do you have a doctor you wish called in the case of a medical emergency?  Yes  No

If so, name of the doctor & telephone number: \_\_\_\_\_

Present Health:  Excellent  Good  Poor

Past Health:  Excellent  Good  Poor

Has any blood relative had:

Tuberculosis:  Yes  No

Diabetes:  Yes  No

Cancer:  Yes  No

Kidney Trouble  Yes  No

Asthma  Yes  No

Are you allergic to any foods or medication? (e.g., aspirin, penicillin, milk, etc?)  Yes  No

If yes, what are you allergic to: \_\_\_\_\_

List any medication(s) that you are presently taking: \_\_\_\_\_

Baby Shots: Mo./Yr. \_\_\_\_\_ Last Booster Shot: Mo./Yr. \_\_\_\_\_

### **AUTHORIZATIONS/CERTIFICATIONS**

Should it be necessary for: \_\_\_\_\_  
(Youth's Full Name)

to have medical treatment while participating in a Health Careers Opportunity Program activity, I give the Health Careers Opportunity Program personnel permission to use their judgement in obtaining medical services for my child. I give permission to any physician selected by the Health Careers Opportunity Program personnel to render medical treatment deemed necessary and appropriate by the physician.

I understand that the Health Careers Opportunity Program has no insurance covering such medical or hospital cost incurred for my child, and therefore, any cost incurred for such treatments shall be my responsibility.

I certify that this information is true to the best of my knowledge.

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

\_\_\_\_\_  
Signature of Student Date

**CALIFORNIA STATE UNIVERSITY, LOS ANGELES  
HEALTH CAREERS OPPORTUNITY PROGRAM (HCOP)**

**CONSENT TO RELEASE INFORMATION**

**TO: ANY PUBLIC OR PRIVATE MEDICAL, PSYCHOLOGICAL,  
EDUCATIONAL, SOCIAL SERVICES AGENCY OR ORGANIZATION.**

I, the undersigned hereby give authorization to release or obtain high school records, and /or pertinent social, medical, and psychological information from your records on my child \_\_\_\_\_  
to the Health Careers Opportunity Program (HCOP) at California State University, Los Angeles for professional use only.

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

\_\_\_\_\_  
Date

**PARENTAL INFORMATION (Confidential)**

**Please Circle One:**

**INCOME LEVEL:**

Number of Family Members*	Income per Year**
1	\$ 10,200
2	13,200
3	15,700
4	20,200
5	23,800
6 OR MORE	26,700

\* Number of Family Members - Includes only dependents listed on Federal Income Tax forms

\*\* Income Level - Adjusted gross income for calendar year 1998

***Please attach a copy of your 1040 Income Tax Form for the previous year.***

**Parents Education:**

Father: 1 2 3 4 5 6 7 8 9 10 11 12 College 1 2 3 4

Mother: 1 2 3 4 5 6 7 8 9 10 11 12 College 1 2 3 4

Language spoken at home: English \_\_\_\_\_ Spanish \_\_\_\_\_ Both \_\_\_\_\_  
Other \_\_\_\_\_

**Family Information:**

Brother/Sister Name	Age	Do they live with you?
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

**ETHNICITY:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> American Indian/Alaskan Native | <input type="checkbox"/> Hispanic _____ | <input type="checkbox"/> African American |
| <input type="checkbox"/> Asian/Pacific Islander         | <input type="checkbox"/> Caucasian      | <input type="checkbox"/> Other: _____     |

I certify that all the information in this application is correct and complete to the best of my knowledge.

\_\_\_\_\_  
Parent(s) Signature

\_\_\_\_\_  
Social Security Number



2. If you know something about the educational level of the student's parents, please comment:

Father: 1 2 3 4 5 6 7 8 9 10 11 12 college 1 2 3 4  
Mother: 1 2 3 4 5 6 7 8 9 10 11 12 college 1 2 3 4

3. Has the student had any serious or chronic illnesses?  Yes  No  Don't know

4. Has the student been in trouble with law enforcement?  Yes  No  Don't know

5. Please provide the following information on other children in the family:

<u>Name</u>	<u>Age</u>	<u>Highest Grade Completed</u>	<u>Now in School</u>
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

6. Is the student now following a college preparatory program?  Yes  No  Don't know

7. Is he/she likely to fulfill the A-to-F requirements of CSLA?  Yes  No  Don't know

9. Please comment on the ways in which you feel the HCOP can assist this student:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Person completing form: \_\_\_\_\_  
Name Position

**Please attach copy of the student's latest transcripts to this form. Thank you.**

