

# FRESNO STATE

Upward Bound Programs

University Center 124

5240 N Jackson M/S UC59, Fresno, CA 93740-8023

Office: (559) 278-2693 or (559) 278-5796 \* Fax: (559) 278-4306

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## Financial Responsibility Form Summer Program 2018

**Please read carefully:**

We are bound by the rules set forth by the university in terms of damage to property. During your child's stay at Fresno State, should your child damage, lose, or destroy any property during the course of the program, his/her parents or guardians will be held responsible for damage costs. This particularly applies to the dormitories, but also covers facilities used by, and visited by, the Upward Bound students.

When damage occurs to a dorm room or to property where more than one student has access, the cost of damages will be divided among the number of students involved. The same rule applies when it cannot be determined who caused damage to an area or suite.

By signing below, you acknowledge the rules and guidelines outlined above and agree to abide by the guidelines set by the Upward Bound Programs and California State University, Fresno.

Thank you for your cooperation and understanding. We are looking forward to a positive and exciting summer.

\_\_\_\_\_  
Student's Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Parent/Guardian's Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian's Signature

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## Emergency Telephone Numbers

Summer Program 2018

Student Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell Number: \_\_\_\_\_

Name of Parent(s): \_\_\_\_\_

Cell/Work Number

Cell/Work Number

*In case parent(s) cannot be reached, please contact:*

Name

Phone Number

Relationship to Student

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

*Add more below if needed.*

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

7. \_\_\_\_\_

8. \_\_\_\_\_

9. \_\_\_\_\_

10. \_\_\_\_\_

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## Consent For Transportation Arrangements Summer Program 2018

I, \_\_\_\_\_, give permission to the following person(s) to pick up my  
Parent/Guardian's Name (please print)

student, \_\_\_\_\_, from the Upward Bound Summer Programs:  
Student's Name (please print)

	<u>Name</u>	<u>Phone Number</u>	<u>Relationship to Student</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

*I recognize that the Upward Bound Programs reserve the right to call me and confirm that prior transportation arrangements have been made for my child. I acknowledge that once my child leaves with the person(s) designated, the Upward Bound Programs will not be held liable.*

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Home Phone Number

\_\_\_\_\_  
Daytime/Work Phone Number

\_\_\_\_\_  
Cell Phone Number

Please list any additional comments or instructions that you think are important for our staff to know regarding pick-up and drop-off:

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

(Please call to inform us when someone else will pick up your student at least 48 hours in advance. A designated person must still sign the student out. Please inform us if you need to add or remove someone off the list so that you can fill out a new form.)

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### Cell Phone Policy

Summer Program 2018

I. \_\_\_\_\_, parent/guardian of \_\_\_\_\_,  
Parent/Guardian's Name (please print) Student's Name (please print)

- Give** permission for my child to bring and use only the following cell phone(s) during the summer program:
1. Cell Phone Number: \_\_\_\_\_ This cell phone belongs to: \_\_\_\_\_
  2. Cell Phone Number: \_\_\_\_\_ This cell phone belongs to: \_\_\_\_\_

**Do not** give permission for my child to bring and use her/his cell phone during the summer program.

My child does not have a cell phone.

I understand that cell phones are not allowed in the classrooms and cannot be used after bedtime hours. Using a cell phone during these times or any inappropriate use may result in confiscation and loss of further cellular privileges. All calls to and from parents/family can be made through the Upward Bound Programs' office and with residential staff consent. Theft, loss, charges, and/or damages to the cell phone are not the responsibility of the Upward Bound Programs.

I understand if there are any changes to this form (change of cell phone number, change of usage, etc.), it is my responsibility to notify Upward Bound Staff.

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Date

Please list any reasons, comments, or instructions that you think are important for our staff to know regarding your student's cell phone:

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## Movie Permission Slip Summer Program 2018

The Upward Bound Programs holds social and/or activities in which students have an opportunity to interact with their peers. The Upward Bound Programs will be selecting appropriate movies that are suitable for minors. Movies are classified into different categories based on the contents of the movie. The different categories and a brief description are provided in this form. Please be aware that some of the movies that will be played for the students might be classified under these four categories.

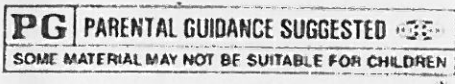
I, \_\_\_\_\_, parent or guardian, do hereby give permission to  
(Name of parent or guardian)  
\_\_\_\_\_ who will be participating in the Summer 2013 Upward  
(Name of Student)

Bound Program to view any movies whose content might be classified: **G, PG, PG-13** and/or **R**.

I also consent to allow my child to walk to Maya Theatre across Fresno State during any movie nights with Upward Bound chaperone staff.



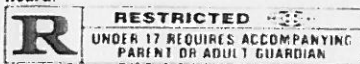
**G** General Audience. All ages admitted. This signifies that the film rated contains nothing most parents will consider offensive for even their youngest children to see or hear. Nudity, sex scenes, and scenes of drug use are absent; violence is minimal; snippets of dialogue may go beyond polite conversation but do not go beyond common everyday expressions.



**PG** Parental Guidance Suggested. Some material may not be suitable for children. This signifies that the film rated may contain some material parents might not like to expose to their young children - material that will clearly need to be examined or inquired about before children are allowed to attend the film. Explicit sex scenes and scenes of drug use are absent; nudity, if present, is seen only briefly, horror and violence do not exceed moderate levels.



**PG-13** Parents Strongly Cautioned. Some material may be inappropriate for children under 13. This signifies that the film rated may be inappropriate for pre-teens. Parents should be especially careful about letting their younger children attend. Rough or persistent violence is absent; sexually oriented nudity is generally absent; some scenes of drug use may be seen; one use of the harsher sexually derived words may be heard.



**R** Restricted-Under 17. Requires accompanying parent or adult guardian (age varies in some locations). This signifies that the rating board has concluded that the film rated contains some adult material. Parents are urged to learn more about the film before taking their children to see it. An R may be assigned due to, among other things, a film's use of language, theme, violence, sex, or its portrayal of drug use.

- I do hereby give permission to \_\_\_\_\_ who will be participating in the  
(Name of Student)

Summer 2017 Upward Bound Program to view any movies whose content might be classified: **G, PG, PG-13**, and/or **R**.

- I do not give my consent for my child to participate in the above-mentioned activities.

\_\_\_\_\_  
(Parent or Guardian Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone Number

Student Health and Counseling Center  
California State University, Fresno  
5044 N. Barton Avenue MS/HC81  
Fresno, Ca 93740-8012

**AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT**

The undersigned (Parent/Guardian) of \_\_\_\_\_

Who is \_\_\_\_\_ years old, hereby authorizes the medical staff of University Health and Psychological Services of California State University, Fresno, as agents for the undersigned to consent to any diagnostic procedure (including x-ray), and the administration of any medical or surgical treatment, when any or all of the foregoing is deemed advisable by and is to be rendered under general supervision of any physician and surgeon licensed under the Provision of the Medical Practice Act.

This authorization is given in advance of any special diagnosis, treatment or medical care being required, and pursuant to the provisions of Section 25.8 of the California Civil Code.

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Print Name

California State University, Fresno University Health & Psychological Services  
**Confidential Health History**

Name \_\_\_\_\_ Student ID \_\_\_\_\_  
Last First M.I.

Local Address \_\_\_\_\_ Date of Birth \_\_\_\_\_

Telephone \_\_\_\_\_ Email Address \_\_\_\_\_

Cell Home  
 May we use phone for confidential message?  Cell  Home  Neither

Gender \_\_\_\_\_ Marital Status:  Single  Married  Divorced  Widowed Primary Language \_\_\_\_\_

Country of Birth \_\_\_\_\_ Are you covered by health insurance?  No  Yes Name of Ins. Company \_\_\_\_\_

Person To Notify In Case of Emergency \_\_\_\_\_ Relationship \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_

List *ALL* medications you currently take (include birth control pills or shots and over-the-counter medications or supplements):

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

List *ALL* allergies/sensitivities to medications or other substances with type of reaction:

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

**Personal Medical History** Have you had or do you have any of the following? Check all that apply & give details below

- |  |  |   |  |  |
|--|--|---|--|--|
| <input type="checkbox"/> Allergies               | <input type="checkbox"/> Eating Disorder     | <input type="checkbox"/> Kidney disease                 | <input type="checkbox"/> Sleep Apnea                 | <input type="checkbox"/> Blood Clots / DVT     |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Headache Migraine   | <input type="checkbox"/> Liver disease                  | <input type="checkbox"/> Stomach/Intestinal Problems | <input type="checkbox"/> Positive TB skin test |
| <input type="checkbox"/> Anxiety or Panic Attack | <input type="checkbox"/> Headache Recurrent  | <input type="checkbox"/> Loss of Consciousness          | <input type="checkbox"/> Stroke                      | <input type="checkbox"/> Serious Injury        |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Mononucleosis                  | <input type="checkbox"/> Substance Abuse             | <input type="checkbox"/> Hearing Loss          |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Overweight/Obesity             | <input type="checkbox"/> Surgery                     | <input type="checkbox"/> Vision Impairment     |
| <input type="checkbox"/> Concussion/ Head Injury | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Psychiatric Problems           | <input type="checkbox"/> Thyroid Disease             | <input type="checkbox"/> Other _____           |
| <input type="checkbox"/> Depression              | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Seizures                       | <input type="checkbox"/> Tuberculosis                | _____  |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Hospitalization     | <input type="checkbox"/> Sexually Transmitted Infection |  | <input type="checkbox"/> No Medical Problems   |

Details of above \_\_\_\_\_

**Family Medical History** Have any of your relatives (parents, grandparents, siblings or children) had any of the following?

Check all that apply and list which relative

- |  |  |
|--|--|
| <input type="checkbox"/> I don't know any family history | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Alcoholism _____                | <input type="checkbox"/> High Cholesterol _____    |
| <input type="checkbox"/> Allergies _____                 | <input type="checkbox"/> Kidney Disease _____      |
| <input type="checkbox"/> Asthma _____                    | <input type="checkbox"/> Melanoma _____            |
| <input type="checkbox"/> Bleeding Problems _____         | <input type="checkbox"/> Mental Illness _____      |
| <input type="checkbox"/> Blood Clots _____               | <input type="checkbox"/> Migraine Headache _____   |
| <input type="checkbox"/> Cancer _____                    | <input type="checkbox"/> Stroke _____              |
| <input type="checkbox"/> Type of Cancer _____            | <input type="checkbox"/> Thyroid Disease _____     |
| <input type="checkbox"/> Diabetes _____                  | <input type="checkbox"/> Tuberculosis _____        |
| <input type="checkbox"/> Drug Abuse _____                | <input type="checkbox"/> Other _____               |
| <input type="checkbox"/> Heart Disease _____             |  |

**Please Turn Over & Complete Other Side**



California State University, Fresno University Health & Psychological Services  
Confidential Health History

Health Habits

Do you now use any of the following?

- Tobacco
- Marijuana
- Other recreational drugs
- Stimulants (non-medical use)
- Other prescription drugs (non-medical use)

How often do you consume alcohol?

- Never
- Once/month or less
- 2-4 times/month
- 2-3 times/week
- 4 or more times/wk

When you drink alcohol, how much do you typically drink in one day?

- < 1 alcoholic beverages
- 1-2
- 3-4
- 5 or more

Have you ever felt you should cut down on drinking alcohol?  Yes  No

Do you exercise regularly?  Yes  No If yes, type of exercise & how often \_\_\_\_\_

Do you have concerns about your diet or nutrition?  Yes  No

Do you use 'safer sex' practices?  Always  Sometimes  Never  Abstinence

Is anyone, including your partner, threatening you, hurting you physically, or causing you to be afraid?  Yes  No

Immunizations

Have you completed the series for Hepatitis B immunization?  Yes  No  Not Sure

Have you had  Chicken Pox  Varicella vaccine  Neither  Not Sure

Have you received the vaccine for HPV (Gardasil)?  Yes  No  Not Sure

Have you received an immunization for meningitis?  Yes  No  Not Sure

I authorize the University Health Services at California State University, Fresno to provide, at my request, all ordinary medical examinations and treatment, as well as any necessary emergency care. I am aware that State Law requires the medical provider to report certain conditions such as injury due to violent assault, loss of consciousness, public health diseases and being a danger to self or others.

Signed \_\_\_\_\_

Date \_\_\_\_\_

Reviewed By \_\_\_\_\_

Date \_\_\_\_\_