

This form cannot be turned in unless the front and back are complete.

**College of the Canyons
Special Admission Form
Summer**

Student's Name: _____
Last First Middle Initial

Student's Address: _____ Social Security #: _____

City/State: _____ ZIP: _____ Phone Number: _____

High School: _____ Grade*: _____ * Indicate what grade you will be in Summer/Fall.

College Course(s) Requested	Section Number	Units	Days	Hours	*Type of Credit

PASS/FAIL CLASSES WILL NOT BE ACCEPTED FOR HIGH SCHOOL CREDIT. COURSES NUMBERED 100 AND ABOVE IN ENGLISH, FOREIGN LANGUAGE, MATH, SCIENCE, & SOCIAL SCIENCE, IF UC/CSU TRANSFERABLE, ARE WEIGHTED.

***To be completed by counselor (please indicate appropriate number):**

- | | |
|---|---|
| 1. Elective Credit | 3. Specific Subject Matter Course Requirement |
| 2. Elective Credit Within A Required Subject Matter | 4. No High School Credit |

Upon submitting a transcript request form, I authorize the release of my college transcript to my high school immediately after the completion of course(s).

Student's Signature

Date

Parent Consent: I give my consent for _____ to be enrolled at College of the Canyons as a special part-time student. I understand that it is my son's/daughter's responsibility to submit a sealed transcript to the high school registrar to receive high school credit for College of the Canyons courses. I understand that my son's/daughter's progress will not be monitored by the high school. In the event the student should drop a course, it is the student's responsibility to notify the high school counselor immediately. I understand that my son/daughter is being considered for admission as a college student and he/she will abide by all college rules, regulations and deadlines. I understand that my son/daughter may participate in college surveys or research as approved by the district. I also understand that transportation and other costs for community college courses are the responsibility of the student. Under FERPA, the College will not release any student records, not including directory information, to anyone without the written consent of my student.

Parent or Guardian's Signature

Date

To: DIRECTOR, ADMISSIONS & RECORDS, COLLEGE OF THE CANYONS, SANTA CLARITA, CA
As Principal, I recommend that this student be permitted to take the college degree applicable classes indicated above. I certify that I have not recommended over 5% of students from any grade level to College of the Canyons during summer. I may exceed the 5% rule if the student is taking class in one of the following three areas; courses that apply toward the IGETC or CSU GE breadth requirements, are part of a career-technical occupational sequence, or this student is a senior who has completed all graduation requirements but has not passed the CAHSEE and the class recommended is for them to pass the CAHSEE .

High School Counselor Signature

Date

High School Principal Signature

Date

STUDENT HEALTH CENTER

AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT OR COUNSELING OF MINORS

Introduction:

On rare occasions students at COC experience illness or accidents while on campus. The College has prepared for such emergencies by establishing a Student Health Center. When asked to respond to an emergency, College staff members are not normally able to take the time to determine if the student needing care is a minor or concurrently enrolled. To protect the interests of our students, as well as the interests of the College, we ask that the parent or legal guardian of every minor student sign this consent form prior to enrolling. Questions regarding this form should be directed to the Dean of Students, or the Director of the Student Health Center.

Please note that we will not enroll minor students without a signed consent form.

Authorization:

The undersigned parent or guardian of _____ who is _____ years old, hereby authorizes the medical and counseling staff of the Student Health Center of College of the Canyons, as agents for the undersigned to consent to any diagnostic procedure (including x-rays), to the administration of counseling, medical, surgical treatment, or to any hospital care when any or all of the foregoing is deemed advisable by and is to be rendered under the general supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act.

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

Signature

Date