ORLANDO SCIENCE SCHOOL TECHNOLOGY CAMPUS

After School Care Program 2018-2019 Registration Form

***This form must be typed**. No handwritten forms will be accepted.

STUDENT INFORMATION

	LAST NAME	FIRST NAME	M.I.	DOB	AGE	GRADE LEVEL
1						SELECT ON
2						SELECT ON
3						SELECT ON

PARENT/GUARDIAN INFORMATION

1

LAST NAME | FIRST NAME | PRIMARY PHONE #

HOME ADDRESS | CITY | STATE | ZIP

EMAIL (Required)

PLACE OF BUSINESS | WORK PHONE #

BUSINESS ADDRESS | CITY | STATE | ZIP

2

LAST NAME | FIRST NAME | PRIMARY PHONE #

HOME ADDRESS | CITY | STATE | ZIP

EMAIL (Required)

PLACE OF BUSINESS | WORK PHONE #

BUSINESS ADDRESS | CITY | STATE | ZIP

EMERGENCY CONTACTS

Note: Parents/Guardians will be contacted first. Other than parents/guardians, provide at least two (2) additional names in the order they are to be contacted:

1

LAST NAME | FIRST NAME | PRIMARY PHONE # | RELATIONSHIP TO STUDENT

HOME ADDRESS | CITY | STATE | ZIP

2

LAST NAME | FIRST NAME | PRIMARY PHONE # | RELATIONSHIP TO STUDENT

HOME ADDRESS | CITY | STATE | ZIP

3

LAST NAME | FIRST NAME | PRIMARY PHONE # | RELATIONSHIP TO STUDENT

HOME ADDRESS | CITY | STATE | ZIP

Parent/Guardian Initials _____

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AUTHORIZED PICK-UP PERSONS

In addition to Parents/Guardians and Emergency Contacts, additional persons may be given authorization to pick-up a student from the After School Care Program. ***Students will not be dismissed to anyone without proper photo identification.***

1

LAST NAME	FIRST NAME	PRIMARY PHONE #	RELATIONSHIP TO STUDENT

HOME ADDRESS	CITY	STATE	ZIP

2

LAST NAME	FIRST NAME	PRIMARY PHONE #	RELATIONSHIP TO STUDENT

HOME ADDRESS	CITY	STATE	ZIP

3

LAST NAME	FIRST NAME	PRIMARY PHONE #	RELATIONSHIP TO STUDENT

HOME ADDRESS	CITY	STATE	ZIP

CONSENT FOR EMERGENCY TREATMENT

Student(s) has special medical needs or allergies: ◯ **NO** ◯ **YES** (Please list below.)

List any allergies, existing illness, previous illness/injuries, hospitalizations during the past 12 months, and/or any medications prescribed for continued, long-term-use.

_____

_____

The school may call 911 or the emergency facility preferred; however the student's well-being may dictate a different facility. All information will be kept private. *Please contact the school office or After School Care Program director immediately if there is any change to information below.*

PREFERRED EMERGENCY FACILITY/DOCTOR		FACILITY/DOCTOR PHONE #	

FACILITY/DOCTOR ADDRESS	CITY	STATE	ZIP

INSURANCE CARRIER	POLICY #	CARRIER PHONE #	

INSURANCE CARRIER ADDRESS	CITY	STATE	ZIP

PAYMENT PLAN (Select ONE)

◯ **Annual** ◯ **Weekly** ◯ **As Needed**

****DUE WITH SUBMISSION OF FORM:****

- **$25 Registration Fee**
- **Credit Card/EFT Authorization Form**
- **1st Payment Based on Plan Selected**

ACKNOWLEDGEMENT & LIABILITY RELEASE

I hereby acknowledge that I have completed this form to the best of my knowledge and **have read and agree to the policies and procedures outlined in the After School Care Program Handbook**. I have also discussed the Handbook with my student(s), listed on Page 1 of this document, and give them permission to participate fully in the Program. We agree to comply with all rules, regulations, and policies set forth in the After School Care Program Handbook and understand violation may result in immediate termination from the program. In addition, we agree to the financial obligation and terms of payment and understand all unpaid balances will result in late fees and possible termination from the program. We also understand any past due balances may be submitted to a collection agency and subsequent collection agency fees applied to the open balances.

The undersigned hereby releases and forever discharges all schools operating under Discovery Education Services, Inc., their officers, servants, agents and employees, from all claims and demands, rights and causes of action of any kind the undersigned now has and thereafter may have an account of or in any way arising from personal injuries known or unknown to the undersigned at the present time and property damage resulting or that results from any occurrence which may happen to student(s), listed on Page 1, during the After School Care Program.

Parent/ Guardian Signature: _____ **Date Signed:** _____

Parent/Guardian Initials _____