BEFORE & AFTERCARE PROGRAM

GATEWAY SCIENCE ACADEMY
ST. LOUIS

STUDENT INFORMATION

NAME_____ BIRTHDATE_____

ADDRESS_____

_____ MALE _____FEMALE

GRADE LEVEL _____

PARENT/GUARDIAN INFORMATION

NAME_____

ADDRESS_____

PHONE NUMBER_____ EMAIL_____

NAME_____

ADDRESS_____

PHONE NUMBER_____ EMAIL_____

MEDICAL INFORMATION

NAME OF PHYSICIAN_____ PHONE NUMBER_____

PREFERRED HOSPITAL_____

ALLERGIES_____

_____

SPECIAL NEEDS OR OTHER MEDICAL INFORMATION_____

_____

EMERGENCY CONTACT INFORMATION

NAME_____

ADDRESS_____

PHONE NUMBER_____

RELATIONSHIPCHILD_____

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NAME_____

ADDRESS_____

PHONE NUMBER_____

RELATIONSHIPCHILD_____

I certify that I am the parent or legal guardian of this student and I have the legal authority to make the representation and grant the authorizations contained herein. I agree to authorize Gateway Science Academy personnel to provide before/after care for my child.

I understand that in case of an emergency, I will be notified. If I can't be reached, I authorize Gateway Science Academy staff to transport my child to the preferred hospital.

I understand that aftercare ends at 6:00p.m. **There is a $10 late fee for the first 5 minutes and $1 per minute after that per child.** After 3 occasions of late pick up, my child may be removed from the program.

I understand that payments are due by the 17th of each month. **Should payments not be made, my child may be removed from the program.**

I understand that I am responsible for bounced check fees and any other fees that may incur.

I understand that administration will be notified of behavior issues with my child. **These behaviors may result in my child being removed from the program.**

_____ _____

Parent's Signature **Date**