

BEFORE & AFTERCARE PROGRAM~2018-2019



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 _____

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. Invoices are sent through Kinderlime. **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