



SAINT MICHAEL SCHOOL

# AFTER CARE PROGRAM

## Registration Form

CHILD 1			
FIRST NAME	LAST NAME	GRADE	SEX <input type="checkbox"/> M <input type="checkbox"/> F
CHILD 2			
FIRST NAME	LAST NAME	GRADE	SEX <input type="checkbox"/> M <input type="checkbox"/> F
CHILD 3			
FIRST NAME	LAST NAME	GRADE	SEX <input type="checkbox"/> M <input type="checkbox"/> F
PARENT/LEGAL GUARDIAN 1 INFORMATION			
FIRST NAME	LAST NAME	RELATIONSHIP	PHONE
PARENT/LEGAL GUARDIAN 2 INFORMATION			
FIRST NAME	LAST NAME	RELATIONSHIP	PHONE

### TERMS AND CONDITIONS

- 1. Permission.** Students may enter the After Care Program only if this registration agreement is signed by the parent(s) or guardian(s) legally responsible for the child(ren).
- 2. Tuition Payments.** Monthly tuition is due and payable on the first (1<sup>st</sup>) day of the month. Write student's name(s) on the memo of the check and indicating "After Care".
- 3. Suspension.** A child is suspended from the program for non-payment of tuition on the first (1<sup>st</sup>) day of the month. A child remaining on suspension for more than three (3) days is dropped from the program.
- 4. Withdrawal.** Tuition for After Care will be refunded for withdrawals as follows:
  - 75% through the 5<sup>th</sup> day of the month
  - 50% through the 15<sup>th</sup> of the month
  - No refund after the 15<sup>th</sup> day of the month
- 5. Attendance.** There are no tuition refunds or deductions for absences, holidays or vacations.
- 6. Tuition & Fees.** After Care is either \$150 per month, or \$20 per day. Late fee for pick-ups after 5:30 PM is \$10 per every 10 minutes.

**I/We have read and agree to the After Care Terms and Conditions as stated above.**

_____	_____	_____
<i>Parent/Guardian Signature</i>	<i>Print Name</i>	<i>Date</i>
_____	_____	_____
<i>Parent/Guardian Signature</i>	<i>Print Name</i>	<i>Date</i>



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## Emergency Information

IN CASE OF ANY EMERGENCY AND PARENTS CANNOT BE REACHED, PLEASE CALL:		
NAME OF EMERGENCY CONTACT PERSON	RELATIONSHIP	PHONE
NAME OF EMERGENCY CONTACT PERSON	RELATIONSHIP	PHONE
FAMILY DOCTOR / OFFICE		PHONE
HEALTH INSURANCE PROVIDER	POLICY NUMBER	
LIST ANY HEALTH PROBLEMS/ALLERGIES		

We, the Parents/Guardians of \_\_\_\_\_, hereby grant permission to St. Michael School to have our child(ren) treated by a physician selected by the school if our child(ren) named above are injured in an accident and need emergency treatment during program hours. This permission is granted only if we and our family physician cannot be reached by phone.

\_\_\_\_\_  
Mother/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Father/Guardian Signature

\_\_\_\_\_  
Date

The following persons are hereby granted permission to escort/pick up my child(ren) from the Saint Michael After Care Program. (List anyone who may pick up your child. No child will be released to anyone not on this list.)

AUTHORIZED PICK-UP 1			
FIRST NAME	LAST NAME	RELATIONSHIP	PHONE
AUTHORIZED PICK-UP 2			
FIRST NAME	LAST NAME	RELATIONSHIP	PHONE
AUTHORIZED PICK-UP 3			
FIRST NAME	LAST NAME	RELATIONSHIP	PHONE

Comments / Additions / Deletion to above list:

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