ORLANDO SCIENCE EAST

After School Care Program 2024-2025 Registration Form

DAYS EXPECTED TO ATTEND

☐ M ☐ T ☐ W ☐ R ☐ F

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

STUDENT INFORMATION

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

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

AUTHORIZED PICK-UP PERSONS/EMERGENCY CONTACTS

For Emergencies: Parents/Guardians will be contacted first. In addition to Parents/Guardians, 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

CHECK ALL THAT APPLY: ☐ **Authorized Pick-up Person** ☐ **Emergency Contact**

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

HOME ADDRESS | CITY | STATE | ZIP

2

CHECK ALL THAT APPLY: ☐ **Authorized Pick-up Person** ☐ **Emergency Contact**

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

HOME ADDRESS | CITY | STATE | ZIP

Parent/Guardian Initials _____

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3	CHECK ALL THAT APPLY: ☐ Authorized Pick-up Person ☐ Emergency Contact			
	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, special needs, 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

REGISTRATION REQUIREMENTS

_____ **Initials of Staff Member Verifying**

☐ $25 Registration Fee
- ☐ Credit Card or EFT provided in the Recurring Payment Authorization Form (**Not Accepted:** American Express).

☐ Registration Form

☐ Recurring Payment Option Form

☐ 1st Payment Based on Plan Selected
- ☐ August 1st
- ☐ Upon completion of paperwork (select if after August 1st)

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 _____