



After School Program Registration Form 2018-19

	<i>First Name</i>	<i>Middle Name</i>	<i>Last Name</i>
<i>Father's</i>			
<i>Mother's</i>			

<i>Home Address</i>	
<i>City, State Zip</i>	

PHONE	<i>Home</i>		
	<i>Father Cell</i>		<i>Mother Cell</i>
	e-Mail		

	<i>First Name</i>	<i>Middle name</i>	<i>Last Name</i>	<i>DoB (mm-dd-yyyy)</i>	<i>Gender (F/M)</i>	<i>Level</i>
<i>1stChild</i>						
<i>2ndChild</i>						
<i>3rdChild</i>						
<i>4th Child</i>						

	<i>Any allergies and precautions</i>
<i>1stChild</i>	
<i>2ndChild</i>	
<i>3rdChild</i>	
<i>4thChild</i>	

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY <small>(Child will not be allowed to leave with any other person without written authorization from parent or authorized representative)</small>		
<i>FirstName LastName</i>	<i>Contact Phone #</i>	<i>Relationship (Parent,Relative,Friend,etc...)</i>

Signature of Parent: _____

Date : _____

AUTHORIZATION AND CONSENT TO MEDICAL TREATMENT OF MINOR:

I (We) the undersigned, parents or legal guardians of above students, do hereby authorize **Redlands PEACE ACADEMY**, to act as agent for the undersigned to consent to any transportation, x-ray examination, anesthesia, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered under the general for special supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act in the State of California, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, hospital care, or transportation being required. It is further understood that this authorization is given to provide authority and power on the part of the afore-mentioned physician in the exercise of his best judgment, may deem advisable. This authorization is given pursuant the provisions of the California Civil Code.



It is understood that as parent(s) of above child/ren, I (We) the undersigned, do hereby agree to be solely and completely responsible for any and all medical treatment costs and transportation costs related thereto, rendered on behalf of said child, pursuant to the AUTHORIZATION AND CONSENT TO MEDICAL TREATMENT OF A MINOR.

Date _____ Parent/legal Guardian Signature _____

Consent to take pictures at school:

Dear Parents/Guardians:

From time to time the school would like to take pictures of the children on special occasions. These pictures may be used for art projects, to place on cubbies for identifications and recognition, etc. If you agree and give consent for teachers to photograph your child(ren), please sign and date in the space provided.

Thank you

Print your name _____

Signature

Date

Tuition for Heritage ASP – Due 1st of every month.

Number of Days/week	Tuition/week
2 days	\$65
3 days	\$75
4 days	\$85
5 days	\$95 +10 for ILC
Minimum Days	Variable
Van Pick up Only	Variable

- ASP Snack fees are 2 payments of \$60/child. **One is due in August and the second one is due in January.**