Office Use:

STUDENT: FULL TIME: _____ DROP-IN: _____

PAYMENTS:

REGISTRATION: _____ METHOD: _____

1ST MONTH: _____ METHOD: _____

ALLERGIES: _____ OTHER: _____

Classé Consultants

AFTERSCHOOL CLASSÉ, LLC

REGISTRATION INFORMATION

(PLEASE PRINT AND COMPLETE ALL INFORMATION REQUESTED)

Date: _____ School: _____ Upcoming Grade: ____

Child's Legal Name (Last, First) _____ Called by _____

Check One: Full Time Student ( ) Part Time Student:( ) Birthdate: ____ /____/____ Sex: ( ) Female ( ) Male

Home Address_____ City _____

Street Address

State _____ Zip_____ County _____ Home Phone # _____

Parent/Guardian Name_____ Social Security # _____

Home Address_____

Street Address City State Zip

(If different from above)

Home Phone #_____

Place of Employment _____ Business Phone # _____

Business Address_____ Cell Phone #_____

Email Address: _____

Parent/Guardian Name_____ Social Security # _____

Home Address_____

(If different from above) Street Address City State Zip

Home Phone #_____

Place of Employment _____ Business Phone _____

Business Address_____ Cell Phone #_____

Email Address: _____

Child Living Arrangements: [ ] Both Parents [ ] Mother [ ] Father [ ] Other: _____

Parent's Marital Status: [ ] Married [ ] Single [ ] Divorced

If divorced who has legal custody? _____

May the non-custodial parent pick the child up? [ ] YES [ ] NO

Non-custodial parent name: _____

Name_____

(PLEASE PRINT AND COMPLETE ALL INFORMATION REQUESTED)

In the event of an emergency, one may contact the following: (Please list emergency contacts below.) Please note: if you are unable to pick up your child/children, he/she/they will be released only to the persons listed here as well.

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to Child: _____

Phone: (_____) _____ Preferred contact # (_____) _____

E-mail: _____

Home Address: _____
(If different from above) Street Address City State Zip

Second parent/guardian or another emergency contact:

Name: _____ Relationship to Child: _____

Phones: (_____) _____ Preferred contact # (_____) _____

E-mail: _____

Home Address: _____
(If different from above) Street Address

Additional contacts in event parent(s)/guardian(s) cannot be reached:

- Name: _____ Relationship to Child: _____

  Phones: (_____) _____ Preferred contact # (_____) _____

  Home Address: _____

  E-mail: _____

- Name: _____ Relationship to Child: _____

  Phones: (_____) _____ Preferred contact # (_____) _____

  Home Address: _____

  E-mail: _____

Note: *Persons that the staff is not familiar with will only be allowed to pick up your student if you have sent written permission beforehand and/or called the Site Director to make special arrangements. This person must show valid identification to pick up your student.*

Name_____

PARTICIPANT HEALTH HISTORY

(PLEASE PRINT AND COMPLETE ALL INFORMATION REQUESTED)

THIS SECTION MUST BE FILLED OUT COMPLETELY (Please list local doctors only.)

Child's Physician_____Phone #_____

Address _____

Hospital Preference_____
(Please note: If preference is not the closest emergency health care facility; ASC will use the closest emergency facility to expedite care for the student.)

Name of child's dentist(s): _____ Phone: (_____) _____

Allergies: ☐ No known allergies

☐ **This child is allergic to** ☐ Food ☐ Medicine ☐ Environment (insect stings, hay fever, etc.) ☐ Other
Please describe below or on the additional sheet what the student is allergic to and the reaction seen.)

Diet, Nutrition: ☐ This child eats a regular diet. ☐ This child eats a vegetarian diet.
☐ This child has special food needs. **(Please describe below or on additional sheet.)**

Immunizations: Are your immunizations current for school? ☐ Yes ☐ No

If your child has not been fully immunized, please sign the following statement:

I understand and accept the risks to my child from not being fully immunized.
Signature of Custodial Parent/Guardian _____ Date: _____

Relationship to Child: _____

Please supply a copy of your child's immunization record.

Copy submitted and attached [ ] YES [ ] NO. Parent contacted about immunization record: _____ by: _____
Date initials

Date received: _____

Medication: **AFTERSCHOOL CLASSÉ DOES NOT ADMINISTER MEDICATIONS.**

☐ This student will not take any daily medications while attending the ASC program.

Medical Insurance Information:
This child is covered by family medical/hospital insurance ☐ Yes ☐ No

Insurance Company _____ Policy # _____
Subscriber _____ Insurance Co. Ph. No. (____) _____

Name_____

PARTICIPANT HEALTH HISTORY (CONTD)

Restrictions:

- ☐ Outside play and activities - I feel the child can participate without restriction.
- ☐ I feel the student can participate with the following restrictions or adaptations. (Please describe below or on a separate sheet.)

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.
Has/does the child:

1. Ever been hospitalized? ☐ Yes ☐ No	9. Had fainting or dizziness? ☐ Yes ☐ No
2. Ever had surgery? ☐ Yes ☐ No	10. If female, have problems during menstruation? ☐ Yes ☐ No
3. Have recurrent/chronic illness? ☐ Yes ☐ No	11. Ever had back/joint problems? ☐ Yes ☐ No
4. Had a recent infectious disease? ☐ Yes ☐ No	12. Have problems with diarrhea/constipation? ☐ Yes ☐ No
5. Had a recent injury? ☐ Yes ☐ No	13. Have any skin problems? ☐ Yes ☐ No
6. Had asthma/wheezing/shortness of breath? ☐ Yes ☐ No	14. Passed out/had chest pain during exercise? ☐ Yes ☐ No
7. Have diabetes? ☐ Yes ☐ No	15. Traveled outside the country in the past 9 months? ☐ Yes ☐ No
8. Had seizures? ☐ Yes ☐ No	16. Had mononucleosis ("mono") during the past 12 months? ☐ Yes ☐ No
9. Had headaches? ☐ Yes ☐ No	18. Wear glasses, contacts, or protective eyewear? ☐ Yes ☐ No

Has the child:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ☐ Yes ☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? ☐ Yes ☐ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? ☐ Yes ☐ No
4. Had a significant life event that continues to affect the child's life? ☐ Yes ☐ No

Please explain "Yes" answers in the space below or on an attached sheet, noting the number of the questions. ASC may contact you for additional information.

EMERGENCY MEDICAL AUTHORIZATION

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the child to whom it pertains. The person described has permission to participate in all activities for the registered program except as noted by me and or an examining physician. I give permission to the physician selected by AfterSchool CLASSÉ to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with the camp staff. I give permission to photocopy this form. Also, the program has permission to obtain a copy of my child's health record from providers who treat my child, and these providers may talk with the program's staff about my child's health status.

Signature of Custodian
Parent/Legal Guardian _____ Date: _____

Relationship to student: _____

PARENTAL AGREEMENT WITH AFTERSCHOOL CLASSÉ, LLC

The AfterSchool CLASSÉ LLC (ASC) agrees to provide after school care for:

_____

CHILD'S FULL NAME

AfterSchool CLASSÉ LLC operates using the Atlanta Public School Calendar.

Hours of operations: Monday thru Friday, 2:30 p.m. until 6:30 p.m.

1. AfterSchool CLASSÉ, LLC provides a daily snack.
2. My child will only be allowed to leave the facility with written permission from parent(s) or person authorized by parent(s). Authorized persons should be listed on the Parent Authorization form.
3. Medication will not be administered in After School Program. (In the event that your child must have medication, please make arrangements for it to be administered during regular school hours by school nurse/medical personnel)
4. I acknowledge that it is my responsibility to keep my child's records current to reflect any significant changes as they occur. (phone numbers, work locations, emergency contacts, medical records, child's physician, child's health status)
5. AfterSchool CLASSÉ, LLC agrees to inform me of my child's progress and any information, updates, incidents, including illnesses, injuries, and exposure to communicable diseases.
6. I acknowledge tuition is not prorated for days missed or days that school is not in session.
7. I agree to abide by the policies and procedures of AfterSchool CLASSÉ LLC.

_____ _____

Signature (Parent/Legal Guardian) Date

AfterSchool CLASSÉ LLC
6411 El Caudillo Court
Atlanta, GA 30349
770-964-4487

www.afterschoolclasse.com

AFTERSCHOOL CLASSÉ, LLC
TUITION POLICY AGREEMENT

AFTERSCHOOL CLASSÉ LLC (ASC) agrees to provide after school care for my child:

_____
Child's Full Name

1. I agree to pay a fifty dollar ($50.00) non-refundable registration fee to reserve my child's space.
2. I acknowledge tuition is due the first of each month. A late fee applies after the fifth of the month.
3. I acknowledge and agree to pay tuition on time and understand failure to do so may result in termination of childcare.
4. I acknowledge a thirty-five-dollar ($35.00) fee applies to returned checks.
5. I agree to abide by the tuition policies of AfterSchool CLASSÉ LLC.
6. I understand the signing Parent/Legal Guardian below is responsible for the tuition payment due.

_____ _____/_____/_____
Signature (Parent/guardian) Date

FIRST AID CARE/EMERGENCY CARE:

I hereby give AfterSchool CLASSÉ, LLC and their staff permission to provide basic first aid care to my child:

_____
Child's Name

In the event of that I cannot be reached, I hereby authorize AfterSchool CLASSÉ, LLC and their staff to authorize transportation of my child to the nearest emergency hospital/medical facility. I hereby grant my consent for the hospital and their medical staff to provide my child with emergency medical treatment. I agree to accept all financial responsibilities for all medical expenses incurred.

_____ _____/_____/_____
Signature (parent/guardian) Date

AfterSchool CLASSÉ LLC
6411 El Caudillo Court
Atlanta, GA 30349
770-964-4487

www.afterschoolclasse.com

AfterSchool CLASSÉ, LLC
MEDIA RELEASE FORM

CHILD'S NAME_____

I hereby consent to my child's name, likeness, picture or voice to be used by AfterSchool CLASSÉ, LLC or the news media. I am aware that my child may be asked a variety of questions (under the supervision of an adult) and the contents of the interview may be published or aired for public view. I understand that my child will be under the supervision of an AfterSchool CLASSÉ LLC staff member during the interview or photo session. Additionally, my child, has the right to terminate interview, photo or video session at any time.

I hereby hold harmless and waive all claims against AfterSchool CLASSÉ LLC or its agents with respect to any liability for the use of my child's name, likeness, picture, and or voice, and against any claim arising out of my child's acts or statements during the interview, photography session or program.

Further, I release AfterSchool CLASSÉ, LLC its agents and employees from any claim which I may assert in the future, arising out of AfterSchool CLASSÉ, LLC publications and its use of the information given and any photograph taken.

PARENT'S/GUARDIAN'S SIGNATURE_____ DATE_____

OFFICE USE:

AfterSchool CLASSÉ LLC
6411 El Caudillo Court
Atlanta, GA 30349
770-964-4487
www.afterschoolclasse.com

Full Time: _____

Drop In: _____

AfterSchool CLASSÉ, LLC
2018-19 Parent Authorization Form

Please attach your $50.00 non-refundable registration fee to reserve your child's space.

Date: _____ School: _____

Child's Name: _____

Parent/Guardian Name: _____ Signature: _____

Phone Number: _____ 2nd Contact # _____

Parent/Guardian Name: _____ Signature: _____

Phone Number: _____ 2nd Contact # _____

Please use the following e-mail address for information/updates:

_____

I authorize the following person(s) to pick up my child from AfterSchool CLASSE, LLC and/or IN THE EVENT OF AN EMERGENCY:

AUTHORIZED PERSON:	ADDRESS:	RELATIONS TO STUDENT:	CONTACT NUMBER:

Print Authorized Name: _____ Authorized Signature: _____

STAFF USE ONLY

Full Time: _____ Drop In: _____ Deposit Method: _____ 1st Month's Payment Date: ___/___/___ Method:

NOTE:/ALLERGIES: _____