PALOS VERDES PENINSULA UNIFIED SCHOOL DISTRICT

ENRICHMENT PROGRAM REGISTRATION FORM

OFFICE USE
Check # _______
Amount_______

Please Print, ONE CHILD ONLY PER FORM, DO NOT PHOTOCOPY, USE ADDITIONAL FORMS AS NEEDED

Child's Name (last name first)______________________________ Sex __________

School ____________________ Grade _______ Classroom Teacher's Name ____________________

Birth date____________________ ***Please write "yes" or "no" to indicate if your child is enrolled in Kids' Corner.**

ENRICHMENT CLASS(ES)	Start Date	***KC yes/no**	Class Fees
			$
			$
			$
			$

REGISTRATION FEE: $ 6.00

I agree to a Total Non-Refundable Fee of: $__________

Method of Payment: ( ) CHECK ( ) MASTERCARD ( ) VISA ( ) AM EX

Credit Card Account Number ____________ Exp. Date ________ Signature ____________ Date ________

PAYMENT POLICY: All Class fees are to be paid in advance, at time of registration. Students may not attend classes unless all fees are paid, including outstanding Kid's Corner and/or District related fees. There are no refunds of fees unless class is canceled due to low enrollment. No credit is given for missed classes and there are no class make-up days. Make checks payable to PVPUSD and attach to registration form.
PICK-UP POLICY AND LATE FEES: Students must be picked-up promptly at the end of class. Students remaining after ten minutes will be taken to Kids Corner and parents will be charged $1 for every minute.

I have read and agree to comply with all policies and procedures stated in the Enrichment Brochure.

PARENT/GUARDIAN SIGNATURE ______________________________ **Date** __________
(Parent/Guardian Responsible for Payment)

PARENT / GUARDIAN INFORMATION

Name ____________________ Name ____________________

Relationship to Child ____________________ Relationship to Child ____________________

Address ____________________ Address ____________________

City & Zip ____________________ City & Zip ____________________

HM# __________ WK/Cell# __________ HM# __________ WK/Cell# __________

E-Mail Address: ____________________

Which parent/guardian should be contacted first in case of illness or emergency? ____________________

ADDITIONAL EMERGENCY INFORMATION

Local persons who may be notified & pick up in case of emergency or illness when the parents/guardians are not available.

Name____________________ HM#__________ WK#__________

Name____________________ HM#__________ WK#__________

CONSENT TO TREATMENT

Child's Name ____________ Allergies/Medical Problems ____________ Specify Treatment/Medication/ Where located ____________

I, *(print clearly)* ____________________, the parent or guardian of the children listed above, consent to any x-ray examination, anesthetics, medical or surgical diagnostic or treatment procedure deemed necessary for their treatment by an emergency physician on duty at a licensed hospital. It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but is given to encourage said physicians to exercise their best judgment as to requirements of such diagnosis or treatment. I understand that I will be contacted as soon as possible and I will be responsible for payment of medical services rendered.

Signature______________________________ **Dated:**__________

Circle Relationship: Father Mother Legal Guardian