2017/2018 SALVATION ARMY
Middle School After School Program Registration Form

Please Circle the month you will be using:
September payment due at time of registration

September	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**
$152	$176	$144	$128	$152	$144	$168	$120	$176	$80

Child's Name_____Birthdate_____ Grade in Fall_____

Home Address_____City_____Zip_____

Mother's Name_____ Mother's cell phone _____

Father's Name_____ Father's cell phone _____

Family email address (for notifications) _____ Home Telephone_____

Mother's location when child is in care_____

Address_____Telephone_____

Father's location when child is in care_____

Address_____Telephone_____

Person other than parent to be notified in an emergency situation when parent is not available: (must be in close proximity)

Name_____Relationship to child_____

Phone_____Address_____City_____Zip_____

Child's MiStar account: (to check assignments online): Optional_____
***The ASP staff checks each student's planners every day and request for each student to fill out their planners daily. This helps ASP staff to assist students with homework or other assignments.

Name of Person/Persons to whom child may **NOT** be released:

1._____

T-shirt size:_____ Do you have a Kidcheck account: Yes_____ No_____(If no, see additional form)

FINANCIAL ARRANGEMENTS**
The customer will still pay for the month regardless if all the days are used due to illness, vacation or any other unforeseen factor.
Payments will be made on the first of the month (or next business day).
Snow days will not be deducted from the monthly fee.
First months fees will need to be paid at registration.
Visa and Mastercard are accepted as well as cash or check.
Checks can be made out to "The Salvation Army" or "The SAL." There will be a $10 charge for any returned checks.
This is a voluntary private program. The SAL reserves the right to ask a student that is repeatedly disruptive to seek alternative after school care.
I promise to pay my monthly fees on time in order to insure my space in the program and that all the above information is correct.

Signature of Parent_____Dated_____

MEDICAL INFORMATION AND TREATMENT RELEASE

Medical Insurance Company_____

Insurance Company Number _____ Group Number_____

Effective Date _____ Insurer's Relationship to child: Father Mother Other_____

Is your child allergic to any medicine? Yes No

If yes,_____

Any Restrictions on activities? Yes No

If yes,_____

Any food allergies and/or restrictions? Yes No

if yes,_____

Any additional comments or information that would be helpful to the SAL Staff?

_____

_____

"My child is in good health and I am responsible for his/her medical well-being."

Signed_____

In the event of an emergency, I hereby authorize and permit such doctors, nurses, hospitals or emergency medical personnel to administer all medical treatment as my child shall require or which they shall deem necessary. I will be responsible for expenses incurred for such treatment.

Dated_____Signed_____

Please check the appropriate box and signature if you give permission for your child to be photographed. Photos may be used for future program media (ie. Slideshows or brochures) ___ Yes ___ No

_____ _____

Signature Date

For Office Use Only
September due at registration

Date received:_____ Amount:_____

Check #:_____ Receipt #:_____