WESTERN PENNSYLVANIA

LEARNING ACADEMY

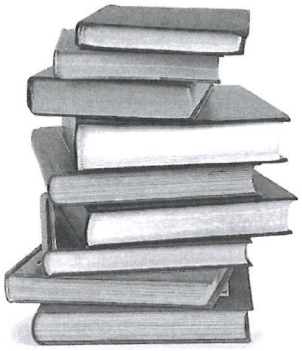
presents

PRACTICE MATERIALS PROVIDED!

SAT® BOOT CAMP

Sunday, September 22, 2024
Noon – 5 p.m.
Fox Chapel Area High School LGI

$100



- Test taking and time management tips
- Intensive grammar & usage skills review
- Intensive math skills review
- Critical reading skills and strategies
- Practice drills with actual test questions
- Experienced and highly-trained instructors

Student Name: _____ Grade: _____

Student Email: _____ School District: _____

Mailing Address: _____

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Email: _____

Please make checks payable to Fox Chapel Area School District (FCASD).

Submit check and completed registration form (front and back) either in person (Fox Chapel Area High School room 168) or via mail to:

Lisa Gibson, Director
Western PA Learning Academy
Fox Chapel Area School District
611 Field Club Road
Pittsburgh, PA 15238

The well-being of any child is a parental responsibility. In an emergency, every effort will be made to contact a parent/guardian. Please list two persons who can arrange transportation and care for your child when you are not available.

Relative or Friend: _____ Phone: _____

Relative or Friend: _____ Phone: _____

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SAT Boot Camp
Program Permission Form

Student Name: _____

I, _____ give permission for my child to attend the assigned date of the Western Pennsylvania Learning Academy's SAT Boot Camp. In the event of an emergency, if treatment is required and parents/guardians cannot be notified immediately, I give consent for emergency treatment and transport to the nearest emergency room.

Does your child have any health concerns that would hinder participation in the field experience? _____ No _____ Yes. If yes, please complete the following:

Please indicate if your child has any of the following health concerns:

_____ Asthma
_____ Life-threatening allergy to bee sting
_____ Life-threatening allergy to food
_____ Seizure disorder
_____ Allergy to _____

_____ Inhaler needed
_____ EpiPen
_____ Benadryl needed
_____ Diabetes

Other _____

Emergency Treatment (if needed): _____

Health Insurance: _____

Family Physician: _____ Phone: _____

My signature confirms that my child has permission to participate in all activities on the specified dates. Permission is also granted to share this information with appropriate academy personnel.

Parent Signature: _____ Date: _____

Cell Phone #: _____ Work Phone #: _____