173 Rhondel Dr.
St. Thomas, PA 17252
717.369.2567

Registration Year: ___________

$20 a day

Days per week: ________

Tuition Cost: _________

Application Fee: $25

The completed application can be emailed to:

impactstaog@gmail.com

Students Name: ___________________________, ______________________, _______
Last First Middle

Gender: ☐ Male ☐ Female Birthdate: ____________ Age:______ Grade: _________

Address: ____

1) Parent/Guardian's Name: ___________________________, ________________
Last First

Phone Number: ___________________, ___________________, ___________________
Home Cell Work

Email: ____

2) Parent/Guardian's Name: ___________________________, ________________
Last First

Phone Number: ___________________, ___________________, ___________________
Home Cell Work

Email: ____

Desired Schedule: Monday Tuesday Wednesday Thursday Friday

By circling your desired days, you are committing to those days and will be billed for those days. You are given **5 excused days** a school year for emergencies and absences where you will not be billed. Please see tuition section in the parent handbook for more information.

Emergency Contact: Please list in order of preference individuals we may contact in event of an emergency. We will contact parents first, then continue to this list.

1. Name: ________________________________ Relation to Child: ________________________

   Address:______________________________ Phone: _______________________________

   ____

2. Name: ________________________________ Relation to Child: ________________________

   Address:______________________________ Phone: _______________________________

   ____

3. Name: ________________________________ Relation to Child: ________________________

   Address:______________________________ Phone: _______________________________

   ____

Medical Information:

Allergies: (Yes) (No) ____

Medical Needs: (Yes) (No) ____

____

____

By signing this application, you are herby swearing that all the information is correct and truthful to your best knowledge. Anything emitted or falsified will disqualify your child from our program. Also by signing this, you are confirming that you will abide by the rules and regulations stated in the parent handbook.

Parent/Guardian Name: ____

Signature: ____ Date: __________________

Parent/Guardian Name: ____

Signature: ____ Date: __________________

AUTHORIZED PICKUP PERSONS

(Not Including Those Listed As An Emergency Contact)

1. Name: ____________________________________ Phone Number:________________

   Relation:____________________

2. Name: ____________________________________ Phone Number:________________

   Relation:____________________

3. Name: ____________________________________ Phone Number:________________

   Relation:____________________

4. Name: ____________________________________ Phone Number:________________

   Relation:____________________

5. Name: ____________________________________ Phone Number:________________

   Relation:____________________

Please note that when a new person or someone unfamiliar picks up your child for the first time, they must have proper identification on hand. Thank you

AUTHORIZATION TO PRODUCE AND USE AUDIOVISUAL MATERIALS

I hereby voluntary and without compensation authorize Impact After School Program and St. Thomas Assembly Of God to produce photographs, movies, videotapes, audio-tapes, and Power Point Presentations of the below named student. This authorization is given on the condition that the materials taken or produced will be used for the purpose of community education or program promotion. I understand Impact After School Program/St. Thomas Assembly Of God and its employees will not use these materials for compensation. I understand that this grant of permission shall only be revoked by a written letter delivered to the director of the Impact After School program. This consent shall remain in effect, unless revoked.

1) Students Name: ____

2) Students Name: ____

3) Students Name: ____

Approve:_________ Deny:_________

Parent/Guardian Name: ____

Signature: ____ Date: _________________

Parent/Guardian Name: ____

Signature: ____ Date: _________________

Emergency Medical Release Form

I, ____________________, hereby give permission that my child,____________________ may be given emergency treatment, to include first aid and CPR by a qualified staff member of St. Thomas Assembly Of God. I further authorize and consent to medical, surgical, and hospital care, treatment, and procedures to be performed for my child by my child's regular physician, or when that physician cannot be reached, by a licensed physician to safeguard my child's health if I cannot be contacted. In such a case, I waive my right to inform consent to such treatment. I also give permission for my child to be transported by ambulance or aid care to an emergency center for treatment. I further authorize said center to take my child to a hospital, and I agree that I will pay all physician's and hospital bills, and said center shall not be responsible for them.

Signature of Parent/Guardian____________________________________ Date______________

Insurance Carrier____

Policy Number____

Policy Holder____

Physician Name & Phone____

Credit/ Debit Card Payment Agreement

To charge a card, we will need the same address and zip code that your bill is mailed to. We also need the 16-digit card number, expiration date, and security code. We can bill you one time only, weekly, or biweekly. You will be emailed a receipt for the amount charged.

Auto Transaction Permission Form

Card Holder Full Name (as it appears on your card):____________________________

Card Number: _________________________________ Security code:_____________

Expiration Date: __________________ Card Type: _____________________________

Address: ____

Date to Start Charging: _______________________ Amount per week:_____________

Signature of Card Holder: _____________________________ Date: ______________

Note: Due to changes in hours, school closings, or other unforeseen billing circumstances, there may be additional charges to your card account. This will include the yearly registration fee being applied to your regular tuition charge when it applies. On a receipt, you will always be informed of any charges and the date when they were charged.

I agree to give St. Thomas Assembly of God permission to charge my credit/ debit card:

Weekly Biweekly One Time Only

For the following dates indicated: Start: ________________ Finish: ________________
If the dates change, I agree to give in writing a two-week notice of the date I would like to stop the weekly auto-debits, or I know my account will continue to be charged.

Signature: __________________________________ Date: ______________________