

Children's adventure company After-School Contract

AGREEMENT BETWEEN CHILDREN'S ADVENTURE COMPANY AFTER-SCHOOL PROGRAM AND _____, PARENT OF _____. In consideration of Children's Adventure Company reserving a place for my child for the after-school enrichment program for a full semester beginning August 2017 and ending in May 2018. I agree to pay monthly fees by the 5th of each month at the rate of:

- \$320.00 Five Days, Full Program M-F**
- \$290.00 4 Days/Week per Month (Including Friday)**
- \$260.00 4 Days/Week per Month (Not Including Friday)**
- \$255.00 3 Days/Week per Month (Including Friday)**
- \$210.00 3 Days/Week per Month (Not Including Friday)**
- \$175.00 2 Days/Week per Month (Not Including Friday)**

A sibling discount of %10 for more than one child will be available.

A \$20.00 service charge will be added for a late payment received after the 5th. Deductions will not be given when a child is sick or taken to other activities.

A \$1.00 a minute late fee will be charged when you arrive after 6:00pm to pick up your child, NO EXCEPTIONS!

Part-time or full-time care is available. You must sign up for a minimum of two days. If you choose Friday, you must sign up for a minimum of three days. Please circle which days of the week you want:

Monday Tuesday Wednesday Thursday Friday

An initial fee of \$250.00 per child, payable to Children's Adventure Company, is required to hold your space in the after-school program. Of the \$250.00, \$150.00 is an activity fee that is non-refundable and will be used to provide extra activities for children. The remaining \$100.00 Deposit per child will be collected at registration and will be refunded or applied to the next year if no days have been dropped or switched during the semester.

Children's Adventure Company Parent Date

School: _____ Age: _____ Enrollment Date: _____

AUTHORIZATION FOR MEDICAL TREATMENT

Student's Name: _____ Birth Date: _____ Sex: _____

Address/Zip: _____ Home Phone: _____

Parents Name: _____ Parents Name: _____

Work Phone: _____ Work Phone: _____

Cell: _____ Cell: _____

Email: _____ Email: _____

Allergies: _____

EMERGENCY CONTACTS In the event we can not reach you:

Name: _____ Name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

CHILD'S DOCTOR OR MEDICAL FACILITY:

Name: _____ Health Insurance: _____

Patient Policy Number: _____ Allergies: _____

Child's Dentist: _____ Phone Number: _____

I hereby authorize Dee Gregory, or another adult responsible agent of Children's Adventure Company, to authorize a licensed physician to administer to _____ (child's name) such medical treatment as said physician may deem necessary or advisable for my child's present or future health, if it is impossible to contact parent or guardian.

I agree to pay all necessary and reasonable costs of medical treatment and hospitalization. I also waive or release the person designated above and the Children's Adventure Company, for any loss, claim or liability, which may result from utilization in effect for the 2017-2018 school year.

Signature: _____ Date: _____

DAILY RELEASE (other than primary pick-up person) CONSENT:

Name: _____ Phone: _____

Name: _____ Phone: _____

(We will release a child only with a note from home to someone other than a parent/guardian/care giver)