

# HOMEWORK CLUB 2021-2022

## ON SM LOWER CAMPUS

### REGISTRATION FORM

Student: \_\_\_\_\_

AGE \_\_\_\_\_ DOB: \_\_\_\_\_

#1 Parent/Guardian: \_\_\_\_\_

Work Ph#: \_\_\_\_\_ Cell Ph#: \_\_\_\_\_

Email: \_\_\_\_\_

#2 Parent/Guardian: \_\_\_\_\_

Work Ph#: \_\_\_\_\_ Cell Ph#: \_\_\_\_\_

Email: \_\_\_\_\_

ParentGuardianSignature \_\_\_\_\_

RATES SUBJECT TO CHANGE DUE TO DISTRICT POLICIES AND RENTAL FEES

<b>HOMEWORK CLUB</b>	<b>3 DAYS</b>	<b>4 DAYS</b>	<b>5 DAYS</b>
<b>HOURS</b>	<b>\$280</b>	<b>\$290</b>	<b>\$300</b>
<b>2:15:00 PM - 6:00 PM</b>	<b>MONTHLY</b>	<b>MONTHLY</b>	<b>MONTHLY</b>
	<b>FLAT RATE</b>	<b>FLAT RATE</b>	<b>FLAT RATE</b>

**NON- REFUNDABLE REGISTRATION FEE DUE WITH FORM: \$75**

*Accepting Venmo: PencilCrayons / 626-864-1513*

STUDENT ALLERGIES \_\_\_\_\_

PHYSICIANS NAME: \_\_\_\_\_ PH# \_\_\_\_\_

PARENT/GUARDIAN

SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_ *In case of actual emergency*

*HC will make every effort to contact parents/guardian of the child involved before any treatment is administered; however in the event we are unable to make contact with you, the parent/guardian, we require this medical release to be signed by all participants.\* I HERBY AUTHORISE THE PHYSICIAN OR HOSPITAL SELECTED BY HC TO HOSPITALIZE to SECURE TREATMENT FOR AND TO ORDER INJECTION, ANAESTHESIA, AND/OR SURGERY FOR MY CHILD.*

**HOMEWORK CLUB/ THE LEARNING CLUB follow state mandated COVID-19 SAFETY STANDERS.**

**ALL PARTICIPANTS must agree to follow protocol while in our program.**

**All participants must wear a facial mask and wash hands.**

*Office use only:*

Start Date: _____	2021 REGISTRATION FEE: (\$75) _____					
8/21 _____	9/21 _____	10/21 _____	11/21 _____	12/21 _____		
1/22 _____	2/22 _____	3/22 _____	4/22 _____	5/22 _____	6/22 _____	