



Student Last Name: _____

Grade: _____

2009-2010 AFTER CARE APPLICATION

Student Information

(One application per student. Siblings must apply separately.) PLEASE PRINT CLEARLY

Grade: Kinder 1 2 3 4 5 6 7 8

Last Name _____ First Name _____ Middle Initial _____

Gender M F Birth Date _____ Current School _____

Does student have any siblings applying for after care? Yes No:

Sibling Name _____ Grade _____

Sibling Name _____ Grade _____

Program Selection

Which plan are you choosing? _____ (Plan A - O) Which days? : (Circle) M T W Th F

Monthly plan fee? _____ Pick-up time? : (Circle) 2:45pm 5pm 6pm

Please choose one of the following for your child : homework time outside time

Are you eligible for LAUSD Free & Reduced Lunch Program? Yes No (If you are eligible and would like to apply for free or reduced tuition, please attach your most recent tax return.)

To reserve your child's space, provide credit card information below.

Card type: (Circle) Visa Master Card Name (as it appears on card) _____

Credit Card # _____ 3-digit security code _____ Exp. _____

Signature _____

First month's plan fee \$ _____

Weds. Surcharge \$ _____ (if applicable)

Enrollment fee \$ 50 _____

Total due with application \$ _____

Please include a check for the total due with application or charge the amount to credit card listed above by checking here :

Parent/Guardian Information

Parent/Guardian 1 Is this person a legal guardian of this child? Yes No Does the child live with this person? Yes No

Last Name _____ First Name _____

Home Address _____ City _____ State _____ Zip _____
(physical address only, no P.O.box)

Home Phone () _____ Work Phone () _____

Cell Phone () _____ Email _____
Please print neatly

Parent/Guardian 2 Is this person a legal guardian of this child? Yes No Does the child live with this person? Yes No

Last Name _____ First Name _____

Home Address _____ City _____ State _____ Zip _____
(physical address only, no P.O.box)

Home Phone () _____ Work Phone () _____

Cell Phone () _____ Email _____

Fill in form completely leaving no field/question blank. If not applicable, designate "n/a".

Emergency Information

Medical Information:

Does the student have any medical conditions the after care program should be aware of? Yes No If yes, please explain; _____

Does the student take any medications? Yes No Medication(s): _____

Is the student allergic to any medications? Yes No Medication(s): _____

Other Allergies: _____

Emergency Contacts: If we are unable to reach a parent/guardian, these contacts will be called. *Please make sure your contacts are aware that you are listing them.* Parent/guardian authorizes after care staff to contact and, if necessary, release the student to any of the following:

Name _____ Relationship _____

Home phone _____ Cell phone _____ Work phone _____

Name _____ Relationship _____

Home phone _____ Cell phone _____ Work phone _____

***The student will not be allowed to leave the after care program with anyone who is not listed on this form without written permission in advance from the parent/guardian. Identification is required.**

Insurance Information:

Name of carrier _____ Policy number _____ ID number _____

Name of insured _____ Physician's name _____ Phone _____

Hospital preference _____

Medical Release

In case of injury or sudden illness, I hereby give authority to any hospital or doctor to render immediate aid as might be required to ensure my child's health and safety. I understand that the expense of this service will be my responsibility.

The undersigned, legal custodian of _____ a minor, hereby authorizes the Ocean Charter School staff, or designee, into whose care the aforementioned minor pupil has been entrusted, to consent to call an ambulance to transport my child to a hospital or medical facility and to any x-ray, examination, anesthetic, medical or surgical diagnosis, treatment, and/ or hospital care to be rendered to said minor upon the advice of any licensed physician and/or dentist.

It is understood that this authorization is given in advance of any required diagnosis, treatment, or hospital care and provides authority and power to the aforementioned agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which a licensed physician or dentist may deem necessary.

This authorization is given through the provisions of Section 25.8 of the California Civil Code and shall remain effective for the full school year unless revoked in writing and delivered to said agent(s). It is understood that Ocean Charter School, its officers and its employees assume no liability of any nature in relation to the transportation of the said minor. It is further understood that the costs of paramedic transportation, hospitalization and any examination, x-ray, or treatment provided in relation to the authorization shall be borne by the undersigned.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Fill in form completely leaving no field/question blank. If not applicable, designate "n/a".

(For office use only)

Date Received Active _____ Non-Active _____ Plan _____ Monthly fee _____

Comments: _____ Staff _____