SCIENCEING TIME
After School Program
Enrollment Packet 2024 - 2025

For Office Use Only:
Start Date _____
Monthly Fee $_____
Received _____

Student's Name _____Grade _____DOB_____

We provide 5-point harness seats_____ height _____weight _____ age

School Name _____ Phone # _____

Teacher's Name _____ Classroom # _____

Parent/Guardian Name _____

Address _____ City _____ Zip Code _____

Cell Phone _____ Email _____

Parent/Guardian Name _____

Address _____ City _____ Zip Code _____

Cell Phone _____ Email _____

Emergency Contact

Medical Insurance _____ Policy # _____

Family Doctor _____ Phone # _____

List three local emergency contacts who agreed to take temporary care of your child/children if a parent/guardian cannot be reached.

Name	Relationship w/Family	Cell #

Dismissal/Sign Out

In addition to the people listed above, my child/children may be picked up the following people.

Name	Cell #

ScienceING Time After School Program
Consent Form

Release of Liability, Waiver, Indemnification Agreement

I _____ the undersigned, hereby authorize my child/children _____ to participate in ScienceING Time After School Program. In consideration for permission to participate, I do hereby, for myself, my family, and on behalf of my child/children, release and agree to indemnify and hold harmless ScienceING Time After School Program, their officers, staff, and volunteers from all liability, loss, claim, demand, action or cause of action which arises or may arise in any way by such participation.

For Emergency Treatment

I authorize ScienceING Time After School Program to arrange for transportation in case of accident or acute illness of the participant. In the event it is not possible to receive instruction for the child's/children's care, consent is given to any licensed physician for treatment. I allow the physician to administer medication and to perform necessary treatment for the preservation of the child's/children's health and well-being. I understand that any cost incurred for treatment of sudden illness or accident shall be paid by me. This authorization and consent for treatment is given to ScienceING Time After School Program with any authorized event.

Field Trips _____ (Initial)

ScienceING Time After School Program may take short field trips on occasion that are within 20 miles of ScienceING Time. We will always return by normal closing time. Five-point restraint car seats and high back boosters will be used. In consideration for permission to participate, I do hereby, for myself, my family, and on behalf of my child/children, release and agree to indemnify and hold harmless ScienceING Time After School Program and their officers, staff, and volunteers, from all liability, loss, claim, demand, action or cause of action which arises or may arise in any way by such participation.

Media Release _____ (Initial)

I hereby consent to the use of my child's likeness and speech in any audio tape, video, or photograph made in ScienceING Time After School Program activities for the business, publicity purposes of ScienceING Time After School Program and on social media platforms for parents and family to see. Child's/children's name will not be used.

I have read the above information and I understand and agree to its content. I am fully aware of the legal consequences of signing this agreement and do so voluntarily.

_____ _____

Parent/Legal Guardian Signature Date

Prescribed Medication Release Form

I, _____ (parent or guardian) give permission to ScienceING Time After School Program to administer the prescribed medication, _____ (name of medication) to my child, _____ (name of child), per my child's doctor's instructions. If an inhaler or nebulizer is needed, an additional form will be needed before administering. I understand that ScienceING Time will not be held liable for any allergic reaction, or other complications that may arise (result) from the administration of the above-named prescribed medication.

_____
Printed Name of Parent/Legal Guardian

_____ _____
Signature of Parent/Legal Guardian Date

Medication Information

Name of child: _____
Any Allergies: _____
Medication(s): _____ Date on bottle: _____
Date medication given to facility: _____
Time medication to be administered each day: _____ _____
Dosage per administration: _____
Doctor prescribing medication: _____
Notes: