**2020-2021 AFTER SCHOOL REGISTRATION** 

**STUDENT INFORMATION:**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(First) (Last)

Gender: Male or Female\_\_\_\_\_ Birth Date\_\_\_ Age:\_\_\_\_\_\_School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CUSTODIAL PARENT OR GUARDIAN INFORMATION:**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (First) (Last)

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**SECOND PARENT INFORMATION:**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(First) (Last)

Address (if different from above)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**AUTHORIZED PICK UP INFO**:

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# IF NOT AVAILABLE IN AN EMERGENCY, NOTIFY, Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PAYMENT INFORMATION: Per Week**

Number of Days Regular Tuition Early Registration Specials!

**4-5 Days / week \* $119.00 5% off 2nd Sibling (4-5 Day Only) 2-3 Days \* $99.00**

**1 Day $79.00**

**Holidays - All Day ($55 per day) & Weekly ($189 per week – Spring Break & Winter Break)**

**$10 Fee Per week for pick up after school hours. (after school activities)**

*Enrolled Days* (Circle the day(s) applicable): (NO MAKE UP DAYS AVAILABLE)

**ALL Mon Tues Wed Thur Fri**

**Registration Fee = $25.00 Non Member / $20 Dynamic Member
Supply Fee - $50 (1 Year)**

 **Monthly Payment Plan – 1st Payment due at registration, and 10 monthly payments of the balance starting September 1, 2019.**

**After Deposit, payments will be made monthly by automatic draft with our billing company we do not accept checks in the school. No refunds or Credits of any kind for missed After School Care days involving vacation, holidays, sick days, doctor appointments or Cancellation and removal by Parent etc. \_\_\_\_\_\_\_\_Initial / Loudoun County Schools \_40\_weeks total**

\_\_\_\_\_\_\_\_ X \_\_\_\_\_ = \_\_\_\_\_\_\_\_\_\_\_+ $\_\_25\_\_\_\_\_+ \_\_$50\_\_\_\_\_\_ = \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Of Weeks $ Per Wk Sub Total Reg. Fee Supply FeeTotal

### Total \_\_\_\_\_\_\_\_\_\_\_ / by Months \_\_\_\_\_\_\_\_ = Monthly Payment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Automatic Payment Option:** Complete and sign this section to make your monthly payment automatically. By signing below I authorize Lee’s Dynamic TKD and its affiliates to initiate and execute a charge on my credit card or debit from the bank account I have indicated. (We accept Master Card, Visa, Discover and American Express) **No *refunds or Credits of any kind* for missed After School Care days involving vacation, holidays, or sick days, doctor appointments, Cancellation or removing child by Parent or guardian etc.**

**Credit Card #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Exp. Date\_\_\_\_\_\_\_\_\_\_** **CID # \_\_\_\_\_\_\_**

**Authorized Signature: X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL INFORMATION:**

Doctor’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dentist Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES** List all known. Describe reaction and management of the reaction.

Medication allergies (list)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food Allergies (list)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Other Allergies (list) – include insect stings, hay fever, asthma, animal dander, etc.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS BEING TAKEN: WE DO NOT ADMINISTER ANY MEDICATION!**

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Attach additional pages for more medications.

#### Med #1\_\_\_\_\_\_\_\_\_\_\_ Reason for taking\_\_\_\_\_\_\_\_\_\_\_\_ Med #2\_\_\_\_\_\_\_\_\_\_\_\_Reason for taking\_\_\_\_\_\_\_\_\_\_\_

**RESTRICTIONS** (The following restrictions apply to this individual)
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EXISTING MEDICAL CONDITIONS**

Use this space to provide any additional information about the participant’s behavior and physical, emotional, or mental health about which the program should be aware.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **IMMUNIZATION (Please give date for last immunization for)**

## Date Vaccine Date Vaccine

 DTP \_\_\_\_\_\_\_\_ Measles (hard or red measles or rubella)

 Rubella TD (tetanus/diphtheria)

 Tetanus Haemophilus influenza B

 Polio Varicella Zoster

 Hepatitis B

Which of the following has the participant had?
Measles \_\_ Chicken Pox German Measles Mumps Hepatitis

**Permission to Provide Necessary Treatment or Emergency Care:**

I hereby give permission to the medical personnel selected by the program director to order X-rays, routine tests, treatment; to *release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In* the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the program director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of facility.

**Parent Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Dynamics reserves the right to dismiss a child from the program whose special needs we are not able to meet or whose conduct is not in the best interests of the program. Dynamics is granted the right to use any and all pictures taken of afterschool activities in their publication of materials for promotion of Dynamic activities. Believing my child(ren) is qualified for Dynamics programs, I give permission for my child to take part in all activities. I agree to place him/her in care of the Dynamics programs, subject to all its rules and regulations. I understand the nature and purpose of the After School and camp activities and I am aware that any strenuous physical activity involves risks. Accordingly, I release, discharge, absolve, and hold harmless Lee’s Dynamics TKD, their affiliates, agents and employees, and instructors, from any and all liability arising out of any accident, injury, or loss sustained by my child as a result of activities at or present in the facility except for accidents, injuries or losses sustained as a result of gross negligence and willful misconduct of the facility. I agree to waive any and all claims against persons connected with Lee’s Dynamic TKD. **I declare to the best of my knowledge my answers are true, correct and complete.**

**Parent Signature** **Date**: \_\_\_\_\_\_\_\_\_\_