2017-18 Aftercare Viking Enrichment Program

(VEP begins immediately after school and closes at 6 PM

(unless otherwise noted)

FULL-TIME Rate (11+ days per month)

Rate for a Family with One Child: $ 200

Rate for a Family with Two Children: $ 250

Rate for family with Three Students: $ 275

PART-TIME Rate (4-10 days per month)

Rate for Family with One Child: $ 125

Rate for a family with Two Children: $ 150

Rate for a family with Three Students: $ 175

Emergency Care (up to 3 days per month)

$ 25/per child per day **OR** $30 for family

(Payment due within 1-2 business days after care)

PLEASE CIRCLE ONE: My child will attend: **FULL-TIME** or **PART-TIME**

Monthly VEP Fees are due on the 1st of every month or a $25 late fee may be incurred
To better manage collection of fees, the office may add VEP monthly fees to your TADS account
Students not picked up by 6 PM will be charged a Late Fee of $10 for every 15 minutes late.

PARTICIPANT INFORMATION

(1)LAST NAME: _____ FIRST NAME:_____

GRADE (2016/17): _____ AGE: _____ GENDER: M F D.O.B. _____

HOME ADDRESS: _____ CITY_____ ZIP_____

OTHER SIBLINGS ATTENDING OLMM :

(2)LAST NAME: _____ FIRST NAME:_____

GRADE (2016/17): _____ AGE: _____ GENDER: M F D.O.B. _____

HOME ADDRESS: _____ CITY_____ ZIP_____

(3)LAST NAME: _____ FIRST NAME:_____

GRADE (2016/17): _____ AGE: _____ GENDER: M F D.O.B. _____

HOME ADDRESS: _____ CITY_____ ZIP_____

(4)LAST NAME: _____ FIRST NAME:_____

GRADE (2016/17): _____ AGE: _____ GENDER: M F D.O.B. _____

HOME ADDRESS: _____ CITY_____ ZIP_____

PARENT/GUARDIAN INFORMATION (PRIMARY)

LAST NAME: _____ FIRST NAME: _____

HOME ADDRESS: _____ CITY _____ ZIP_____

HOME PHONE NUMBER: _____CELL/WORK: _____

PARENT EMAIL: _____

PARENT/GUARDIAN INFORMATION (SECONDARY)

LAST NAME: _____ FIRST NAME: _____

HOME ADDRESS: _____ CITY _____ ZIP_____

HOME PHONE NUMBER: _____CELL/WORK: _____

PARENT EMAIL: _____

Emergency Contact if Parent(s) CANNOT be reached: _____

Name Relationship to Child

_____

Contact Number(s)

MEDICATIONS

The participant takes the following **routine** medications (including over-the-counter/non-prescription medications)

STUDENT'S NAME: _____

Name of Medication	Strength (e.g. "100 mg")	Dosage (e.g. 2 pills)	Prescribing Physician	Reason for taking	Other instructions

The participant takes the following medication AS NEEDED (includes inhalers, epi-pens, oral medications, topical medications, etc)

Name of Medication	Strength (e.g. "100 mg")	Dosage (e.g. 2 pills)	Prescribing Physician	Reason for taking	Other instructions

Allergy	Reaction	Management of Reaction

PARENTAL SIGN OUT CONSENT FORM & AGREEMENT

As the Parent/Guardian of _____, I agree to sign out my child from the Viking Enrichment Program or have someone designated in writing to pick up/sign-out my child. ***I understand my child Does NOT have permission to sign themselves out of the Viking Enrichment Program.***

Only the people listed below have permission to sign out my child with valid identification.
When signing out a child the designated adult (age 18 or older) must present a valid ID as form of identification with a photo to the Viking Enrichment Program Staff in order for the child to be released.

IF THERE IS A COURT ORDER REGARDING CUSTODY OF THIS CHILD, A COPY OF THE COURT ORDER MUST BE ON FILE WITH THE VIKING ENRICHMENT PROGRAM.

The following individuals are authorized to pick up my child/children:

Name #1_____
Relationship:_____
Phone:_____

Name#2_____
Relationship:_____
Phone:_____

Name#3_____
Relationship:_____
Phone:_____

Name#4_____
Relationship:_____
Phone:_____

I understand that if my child behaves contrary to the philosophy of the school, he or she may be requested to be picked-up early and/or denied the privilege of attending the after-school VEP program.

Parent/Guardian
Signature_____Date_____