2019-20 Viking Enrichment Program
Aftercare Application

(VEP begins immediately after school and closes at 6 PM, unless otherwise noted)

FULL-TIME Rate (11+ days per month)		**PART-TIME Rate** (4-10 days per month):
Rate for a Family with One Child:	$ 200	$ 125 one Student
Rate for a Family with Two Children:	$ 250	$ 150 two Students
Rate for a Family with Three Children:	$ 275	$ 175 three Students

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)

- Monthly VEP Fees are due on the 1st of every month or a $30 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.

PLEASE CIRCLE ONE: My child will attend: **FULL-TIME** or **PART-TIME** or **EMERGENCY DROP-IN *ONLY***

STUDENT'S INFORMATION

LAST NAME: _____ FIRST NAME:_____

GRADE (2018/19): _____ AGE: _____ GENDER: M F D.O.B. _____

HOME ADDRESS: _____ CITY_____ ZIP_____

DOES THIS STUDENT HAVE SIBLINGS AT OLMM SCHOOL? YES or NO

LIST NAME OF SIBLINGS AT OLMM:_____

PLEASE COMPLETE A SEPARATE AFTERCARE APPLICATION FOR THESE STUDENTS

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: _____

STUDENT'S NAME: _____

EMERGENCY CONTACT INFORMATION

Please list the Emergency Contact person below 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)

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

SEE PAGE 3 – PARENTAL SIGN OUT CONSENT FORM & AGREEMENT

STUDENT'S NAME: _____

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.

*****IMPORTANT: Under no circumstances will a child be released to anyone other than the individuals listed below.***

*****IMPORTANT: 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.

Name #1_____Relationship:_____

Phone:_____

Name #2_____Relationship:_____

Phone:_____

Name #3_____Relationship:_____

Phone:_____

Name #4_____Relationship:_____

Phone:_____

Name #5_____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' Name – Please Print

_____

Parent/Guardian Signature **Date**