

ASPIRING LEADERS ENRICHMENT CENTER
LEADERS AFTERSCHOOL
REGISTRATION FORM

Student ID:

Date:

Student: M() F()	Parents Name	Address & Parent's E-mail
Name:		Address:
DOB:		Email:

School & Grade	Parent's Number	Emergency Contact & Physician
School: _____	() _____ - _____	Dr. _____ Phone: () _____ - _____
Current Grade: _____	() _____ - _____	When parents are not available, please contact: Name: _____ Phone: () _____ - _____

Payment (office use only)	Allergies & Medical Conditions	Pick Up Person Authorized by Parent <i>(Please provide name, address and phone number.)</i>
Tuition & Fees:	<i>*We do not administrate medication or lotion to our student*</i>	
Check Number:		
Adjustments:		

Program	Parent/Guardian Consent	
Registration fee \$50	<p>By signing this form, I hereby agree to the terms & conditions listed in the section below as well as on our website. I agree to relieve Aspiring Leaders Enrichment Center, Leaders after school, herein referred to as "ALEC", "Leaders" or "LAS," of its officers, staff or volunteer of all liability/responsibility for any mishap(s) resulting from providing care to my child. I further consent that I will not hold Leaders after school, and its affiliates, Aspiring Leaders Enrichment Center liable. I will not engage in any litigation against "Leaders after school or ALEC" and its officers, staff & volunteer concerning my child's well being. I assure Leaders after school that my child is in good health and has no pre-existing medical conditions that prevents him/her from participate in gym or playground activity. I give permission for any pictures and videos taken of my child during program activities to be used in forms of print or digital by ALEC for informational, advertising/promotional or training purposes. I have read & understand this waiver clause; I am the parent or legal guardian with legal power to sign this document for the registering child.</p>	
Semester Plan \$2050		
Monthly Plan \$445		
Weekly Plan \$150		
Daily Plan \$33		
Half Day /Early Dismissal \$25		
Late Pick up \$15/Per Half Hour		
Return check fee \$30		
<p>*Semester plans are available September and February. The second child of the same family will receive a \$250 discount only on semester plans.</p>		
<p>***Please make checks payable to "ALEC"*** (Aspiring Leaders Enrichment Center)</p>		
<p><i>*Payments are due before the start of the program or a late fee may apply*</i> \$10 late fee for past the first week of semester plan or monthly plan, additional \$20 for payment made past 2nd week. Leader After School reserve the right to discontinue its service to the child if parent repeatedly late for payments. Twice in any 3 consecutive month for monthly plan, or owe over a week for weekly/daily plan.</p>		
<p>Name: _____ Signature: _____ Relationship to child: _____ Date: _____</p>		

Notes:

45-52 193 St. Flushing, NY 11358

www.LeadersSummerCamp.com | LeadersAfterSchool@gmail.com

For registration appointment, please call 917.567.4737 or 718.286.9860 Phone & Fax 718.357.6524

HEALTH RECORD FOR CHILDREN IN DAY CAMPS & AFTER SCHOOL & YOUTH CENTERS

(This side to be filled in by parent before presentation to physician)

NAME OF PROGRAM Leaders After School

_____/_____/_____ M F
Children's Last Name First Name Birth Date Sex

Home Address: _____ Phone: _____

Parent or Guardian: _____ Phone: _____

Parent's cell phone (Mom/Dad) _____ E-Mail _____ @ _____

Place of Employment: Father (Guardian) _____ Phone: _____

Mother (Guardian) _____ Phone: _____

In case of emergency, notify: _____ Phone: _____

If Parent, Guardian are not available in an emergency, notify:

1. _____ Phone: _____

or 2. _____ Phone: _____

Important Has this camper been exposed to any communicable disease during the three weeks prior to camp attendance:

Yes No (If yes, state type of exposure: _____)

HEALTH HISTORY: _____ (Check box if child has had afflictions, give appropriate dates)

Allergies

Rheumatic Fever _____ Hay Fever _____

Seizures _____ Poison Ivy, etc. _____

Diabetes _____ Insect Stings _____

Asthma _____ Penicillin _____

Chicken Pox _____ Other Drugs _____

Food _____

Other Past Illnesses _____

Operations or Serious Injuries(Dates) _____

Hospitalization (Dates) _____

Chronic or Recurring Illness _____

Any specific activities to be encouraged? _____

Conditions that require activity to be restricted? _____

Permission for all program activities unless otherwise noted by Dr. _____

Appliance worn (glasses, contacts, etc.) _____

Medication taken _____

Suggestion from Parent/Guardian _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I do hereby give authority to the Leaders Day Camp and Year Round Afterschool Program staff to obtain necessary emergency medical treatment for my child with the understanding that the family will be notified as soon as possible.

Relationship to the child _____ Signature: _____ Date _____ Tel.# _____