

# Registration Checklist

Student name \_\_\_\_\_ Parent Name \_\_\_\_\_

My child meets the enrollment criteria

\_\_\_\_\_  
Parent initial

\_\_\_\_\_  
Employee initial

I understand the payment process

- Schedule
- Late fees

\_\_\_\_\_  
Parent initial

\_\_\_\_\_  
Employee initial

I understand the hours of service

- Times 7am-9am

\_\_\_\_\_  
Parent initial

\_\_\_\_\_  
Employee initial

Medication(s) and allergy information is on application

- Conditions
- Taken during the hours of the program

\_\_\_\_\_  
Parent initial

\_\_\_\_\_  
Employee initial

I understand the program is not prorated.

Each student receives one absence week per year.

\_\_\_\_\_  
Parent initial

\_\_\_\_\_  
Employee initial

I understand that a tax statement is not provided.

- Tax ID is on receipts
- Retain receipts for tax purposes

\_\_\_\_\_  
Parent initial

\_\_\_\_\_  
Employee initial

My child or I will notify staff of school related activities

\_\_\_\_\_  
Parent initial

\_\_\_\_\_  
Employee initial

Review break-in service

\_\_\_\_\_  
Parent initial

\_\_\_\_\_  
Employee initial

## **PARENT ACKNOWLEDGEMENT**

I, \_\_\_\_\_ have read over and understand the payment information, schedule and policy. I understand the enrollment criteria stated for the Before the Bell Program, and that my child's enrollment in the program may be subject to cancellation if he/she is unable to follow the criteria listed above. I understand that the account is the responsibility of the enrolling parent/guardian.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

**THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FLORIDA**  
 Extended Day Program  
**EMERGENCY PROCEDURE CARD**



**PLEASE PRINT ALL INFORMATION**

School \_\_\_\_\_

Student's Full Name \_\_\_\_\_ Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First Middle

Student's Social Security Number \_\_\_\_\_ Race \_\_\_\_\_ Sex \_\_\_\_\_ Home Phone Number \_\_\_\_\_

Home Address \_\_\_\_\_ Place of Birth \_\_\_\_\_  
No. Street Apt. # City State Zip City State Country

Father/Guardian Name \_\_\_\_\_ Work Address \_\_\_\_\_ Work Phone (\_\_\_\_\_) (\_\_\_\_\_) (\_\_\_\_\_)  
Area Code Ext.

Mother/Guardian Name \_\_\_\_\_ Work Address \_\_\_\_\_ Work Phone (\_\_\_\_\_) (\_\_\_\_\_) (\_\_\_\_\_)  
Area Code Ext.

Alternate Person To be Notified \_\_\_\_\_ Phone (\_\_\_\_\_) (\_\_\_\_\_) (\_\_\_\_\_)  
Area Code Ext.

If emergency treatment is required, can the Extended Day Program send the child to the hospital or doctor most easily accessible before parents are reached?  Yes  No  
 Preferred Hospital \_\_\_\_\_ Preferred Doctor \_\_\_\_\_ Dr. Office Phone (\_\_\_\_\_) (\_\_\_\_\_) (\_\_\_\_\_)  
Area Code Ext.

Does the child have any physical disabilities?  Yes  No If yes, please describe \_\_\_\_\_

Does the child have allergies?  Yes  No If yes, please describe \_\_\_\_\_

For headache or minor illness, may the child take: An aspirin substitute  Yes  No Pepto-Blarnol  Yes  No

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

An Equal Opportunity Agency

FC-740-1513 (Rev. 6/96)

**THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FLORIDA**

CONSENT AND RELEASE TO PHOTOGRAPH/VIDEOTAPE/INTERVIEW STUDENT

I, \_\_\_\_\_ the parent/ guardian of \_\_\_\_\_  
Print Parent/Guardian Name Student Name

Student ID# \_\_\_\_\_ Grade \_\_\_\_\_, a student at \_\_\_\_\_ school on behalf of my child,

**Do Consent**  **Do Not Consent** to the photographing/videotaping/interviewing of my child while he/she is involved in any school programs and/or activities during the present school year. I also consent to the release of my child's name, both verbally and in print, when used in connection with said photograph/videotape/interview. It is understood the photograph(s)/videotape(s)/interview(s) and the name of my child may be used for promotional purposes inside and/or outside of the School District of Osceola County, Florida, including but not limited to, on social media sites and applications.

I do hereby release and waive any and all claims, demands, or objections against the said school and School District in connection with or arising out of the said photograph/videotape/interview of my child.

It is understood that the school or School District will not duplicate photograph(s)/videotape(s)/interview(s) for the use or benefit of any individual student or parent/guardian. It is also understood that failure to return this permission form to the school will constitute parent/guardian consent for the purposes described above.

\_\_\_\_\_  
 Parent/Guardian Signature Date

An Equal Opportunity Agency

FC-600-1386ERS (Rev. 04/29/14)