Children's Garden Montessori School
Before/After Care Form

This form is required to participate in the Before/After Care programs.

Please select one or both:

_____ Before Care _____ After Care

Student's Name_____

Gender: Female / Male Birth date: _____

Parent/Guardian Name(s):_____

Home Address _____ City_____ Zip Code _____

Daytime Phone _____ Evening Phone _____

Cell Phone _____

Emergency Contact

Does your child have health insurance? Yes No

Insurance Company _____ Policy # _____ Group _____

Family Doctor Name _____ Phone Number _____

In case of emergency and the parent or caregiver cannot be reached, please notify:

Name _____ Relationship to family _____

Address _____ City _____ Zip Code _____

Daytime Phone _____ Evening Phone _____

Cell Phone _____

Please list any current medications, medical conditions, recent injuries, and food or drug allergies (and reactions):

_____

Dismissal/Sign Out (For After School Only)

My child may be picked up by the following adults (list all names):

_____ _____

_____ _____

General Release of Liability

In consideration of the Children's Garden Montessori School's acceptance of our child in the Before / After Care Programs, as parents, we hereby release and discharge the school, its agents or employees, from any and all liability, claims or demands arising out of any incident, act or omission to act which could give rise to a claim or demand against the school, its agents or employees, which claim or demand would allege negligence, on the part of the school, its agents or employees, assert able by us as parents of _____ or on our own, or by our child. Specifically excepted from the operation of this waiver is liability for any incident, act or omission to act by the school, its agents or employees, which liability would be based upon willful and wanton misconduct or gross negligence.

For Emergency Treatment

I authorize the CGMS Before /After Care Programs to arrange for transportation in case of accident or acute illness of the participant. In the event it is not possible to receive instruction for the participant's care, consent is given to any licensed physician for treatment. I allow the physician to administer medication and to perform necessary treatment for the preservation of the participant's health and well-being. I understand that any cost incurred for treatment of sudden illness or accident shall be paid by me. This authorization and consent for treatment is given to the CGMS Before / After Care Programs and in conjunction with any authorized event.

Payment

Tuition is as follows:

<u>Before Care Program</u>: $20 / week; $60 / month; $500 / year

<u>After Care Program</u>: $75 / week; $275 / month; $2,500 / year

<u>Drop–in After Care</u>: $20 per student per day

<u>Drop-in Before Care</u>: $6 per student per day

As parents of _____ we agree to the aforementioned terms and conditions of the CGMS Before / After Care Program.

Signed,

_____, _____

Parent Parent

_____

Head of School