Little Sweet Angels 小天使 - 課後輔導

Site 1: 146-27 Beech Ave Suite 1B Flushing, NY 11355 Site 2: P.S.214 31-15 140 Street Flushing, NY 11354
Phone: 718-888-1819 -- Fax: 347-368-6666 -- Email: info@littlesweetangels.com

After school Registration Form

LAST NAME 姓: _____ FIRST NAME 名: _____ GENDER: ☐ F 女孩 ☐ M 男孩

D.O.B (MM/DD/YY) 出生日期 (月/日/年): _____/_____/_____

SCHOOL 目前就讀學校: P.S. _____ Grade 年級: _____

PARENT/GUARDIAN 家長/監護人名字: _____ RELATIONSHIP關 係: _____

ADDRESS 住址: _____

CITY市: _____ STATE州: _____ POSTAL CODE區域代號: _____

TELEPHONE NUMBER電話: 1._____ 2._____

PARENT EMAIL ADDRESS父母親電子信箱:1. _____ 2._____

EMERGENCY CONTACT 緊急聯絡人 (MUST A DIFFERENT PERSON FROM LIST ABOVE 必需是與上述家長/監護人不同名字的人)

PERSON NAME名字: _____ RELATIONSHIP關 係: _____

TELEPHONE NUMBER 電話: 1. _____ 2._____

PHYSICIANS NAME 醫生名字: _____ OFFICE TELEPHONE 電話: _____

ALLERGIES/MEDICAL CONDITION 過敏/醫療狀況: _____

ERTREMLY SERVERE ALLERGE TO對什麼會非常嚴重过敏:_____

WHICH OF HEALTH INSURANCE DOES STUDENT HAVE? 學生有那一種健康保險?

☐ PRIVATE HEALTH INSURANCE ☐ MADICAD ☐ CHILD HEALTH PLUS B ☐ OTHER _____

TRANSPORTATION? 需要校車接送? YES需要_____

I as the parent/legal guardian of student the name listed above, hereby consent give permission to LITTLE SWEET ANGELS transportation to pick-up and drop-off daily for my child.

PRINT NAME 家長/監護人的打印簽名X _____ SIGNATURE 家長/監護人的簽名X _____ DATE日期: _____

IMPORTANT: PARENT/GUARDIAN MUST SIGN 家長/監護人閱讀後請簽名

I do hereby authority to the Little Sweet Angels staff to obtain necessary emergency medical treatment to my child, with the understanding that the family will be notified as soon as possible. I understand that I am responsible for my child medical or medication needs and further agree that in an emergency and/or if cannot be reached, the Little Sweet Angels, through its agents and employees, may take whatever action is deemed necessary with respect to my Childs health and safety. I authorize the Little Sweet Angels, its agents and employees, to place my child, at their discretion and without my further consent, in a hospital or in the care of a medical professional for medical services and treatment and to arrange necessary related transportation for me and/or my child. I understand that I will be fully responsible for any fees and expenses for any service and/or treatment.

I understand the after-school director reserves the right to dismiss a student who, after careful consideration and examination, is deemed a hazard to the safety or rights of others persons. I understand that if I have changed my contact information; like contact number and house address, I will inform office of Little Sweet Angels immediately.

LITTLE SWEET ANGELS IS LICENSED BY THE NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE AND IS INSPECTED TWICE YEARLY.

I HEREBY CERTIFY THAT I HAVE READ AND ACCEPTED ALL THE ABOVE CONDITIONS AND THE INFORMATION THAT I PROVIDED ABOVE IS ACCURATE.

PRINT NAME 家長/監護人的打印簽名X _____ SIGNATURE 家長/監護人的簽名X _____ DATE日期: _____

OFFICIAL USE ONLY

Starting Date: _____

First month tuition: $_____ (count for the date from _____ to _____)

First Month Payment $_____ Bank/Check # _____

Date Received: _____ Received Person: _____