

**SACRED HEART GRADE SCHOOL
APPLICATION FOR AFTERSCHOOL PROGRAM
2021-2022 SCHOOL YEAR**

APPLICATION INSTRUCTIONS:

1. Complete all sections of this form (front & back).
2. Complete attached Emergency Form
3. Attach a \$20.00 application fee.
4. Return to ASC Coordinator or School Office.

HOURS OF OPERATION:
2:30 p.m.-5:30 p.m.
Monday-Friday
(when school is in session, full day)
FEE: \$55.00/week - billed monthly

STUDENT INFORMATION (Please print clearly)

Effective Date: _____

NAME: Last: _____ First: _____ Nickname: _____

Date of Birth: _____ Gender: ___M ___F Grade: _____

PARENT INFORMATION (Please print clearly)

Child's Father's Name: Last: _____ First: _____ Title: _____

Street: _____ City: _____ Zip: _____

Mobile Phone: _____ Work Phone: _____

Email: _____

Child's Mother's Name: Last: _____ First: _____ Title: _____

Street: _____ City: _____ Zip: _____

Mobile Phone: _____ Work Phone: _____

Email: _____

BILLING INFORMATION (Please print clearly)

After School Care fees will be paid by, and billed to, the following: (Please note that we do not accept 3rd party payments such as CONNECT.)

Name: _____

Address: _____

List any special dietary needs or food/medicine allergies your child may have

I grant permission for my child to participate in field trips, water activities or other special events planned by SHASP.

Parent signature granting permission

Parent signature denying permission

I grant permission for the SHASP to take photographs or make audio and/or video of my child as related to the program and post on the PRIVATE SHASP Facebook Page.

Parent signature granting permission

Parent signature denying permission

The following person(s) have permission to take my child from the SHASP. I understand I **must send written notice that day**, and may not call the center, granting permission for someone other than the parent or guardian to pick up my child. **PLEASE NOTE: A picture ID is also required at pickup (e.g. Driver's License)**

Name: _____

Cell Phone: _____

Address: _____

City: _____

Zip: _____

Relationship: _____

Name: _____

Cell Phone: _____

Address: _____

City: _____

Zip: _____

Relationship: _____

Name: _____

Cell Phone: _____

Address: _____

City: _____

Zip: _____

Relationship: _____

I understand that all fees will be charged at a weekly rate and billed monthly through the Parish Business Office. I understand that I must give one week written notice if my child(ren) will no longer attend the SHGS ASC Program in order to not be invoiced for services. I understand that if I am one month delinquent in payment that my child(ren) will be removed from the program.

Signature of Parent or Guardian

Date

Revised 12/20