**THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FLORIDA**
**EXTENDED DAY PROGRAM**
1200 Vermont Ave. Bldg. 12-106A
Saint Cloud, Florida 34769
Phone: (407) 343-8780 Fax # (407)343-8652

## EXTENDED DAY PROGRAM REGISTRATION

School Name _____ Enrollment Date _____

Student Name _____ Birth-date _____ Age _____ Grade_____

Social Security Number _____ Sex _____ Race _____

Home Address _____ Zip _____ Phone _____

Mother's Name _____ Place of Business _____ Work Phone _____

Father's Name _____ Place of Business _____ Work Phone _____

Doctor's Name _____ Office Phone _____

Any Medical Problems? _____ Explain _____

Taking any Medications? _____ Explain _____

Special Diet _____

Emergency contact _____
Name Address Phone Relation

Name of persons permitted to pick up child from the Extended Day Program (include yourself):

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

I hereby consent for my child to participate in the Extended Day Program and agree to release and discharge the Osceola County School Board, its officers, agents, and employees, exercising reasonable care within their scope of employment, from all liability claims, damages, suits, judgments, and settlements involving personal injury and property damage resulting from or arising in connection with the Extended Day Program. **I have received a copy of the Extended Day Program Brochure.**

Date _____ Parent or guardian (Print) _____

Parent or Guardian Signature _____

**FOR OFFICE USE ONLY**

Staff:_____

Date _____ Tuition Rate $ _____ Registration Fees $ _____ Receipt # _____

White: Office
Yellow: School

An Equal Opportunity Agency

FC-740-1297
Rev. (04/08)

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

Extended Day Program

**EMERGENCY PROCEDURE CARD**

_____

School

PLEASE PRINT ALL INFORMATION

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

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

Mother/ Work Work
Guardian Name _____ Address _____ 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 Preferred Dr. Office
Hospital _____ Doctor _____ 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-Bismol ☐Yes ☐ No

PARENT/GUARDIAN SIGNATURE _____ DATE _____

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

CONSENT AND RELEASE TO PHOTO GRAPH / VIDEOTAPE STUDENT

I _____ the parent / guardian of _____
Parent / Guardian Name Student Name

☐ **Do Consent /** ☐**Do NOT Consent** to the photographing/videotaping 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 use in connection with said photograph/videotape. It is understood the photograph(s)/videotape(s) and the name of my child may be used to promotional purposes inside and/or outside of the School District of Osceola County, Florida.

☐ **Do Consent /** ☐**Do NOT Consent** to the use of the above mentioned photograph(s)/videotape(s) and the name of my child for promotional purposes on the Internet.

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/video of my child,

It is understood that the school or school district will not duplicate photograph(s)/videotape(s) for the use or benefit of any individual student or parent. 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

**THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FLORIDA**
**EXTENDED DAY PROGRAM / *PROGRAMA DE DÍA EXTENDIDO***
1200 Vermont Ave. Bldg. 12-106A St. Cloud, Florida 34769
Phone: (407)343-8780 / Fax (407-343-8652

## EXTENDED DAY PROGRAM ADDITIONAL FEES
***CARGOS ADICIONALES DEL PROGRAMA DE DÍA EXTENDIDO***

**LATE PAYMENT FEE:** If weekly payment fee is not paid on Monday at the sites, or received in the Extended Day Program Main Office every Tuesday, no later than 4:00 P.M., your account will be charged a $12.00 fee.

***CARGO POR RETRASO EN EL PAGO:*** *Si no se paga el cargo semanal los lunes en los recintos [del Día Extendido] , o si no se recibe el pago semanal en la Oficina Principal del Programa de Día Extendido, a más tardar a las 4:00 p.m., se le cargará a su cuenta un cargo de $12.00.*

**LATE PICK UP FEE:** $10.00 per child the first 15 minutes, after that $12.00 per child every 15 minutes.

***CARGO POR RETRASO EN RECOGER:*** *$10.00 por niño/a por los primeros 15 minutos; luego de ello, $12.00 por niño/a por cada 15 minutos de retraso.*

**RETURNED CHECK FEE:** $12.00

***CARGO POR CHEQUE DEVUELTO:*** *$12.00*

I, the parent/guardian of _____, a student at_____ understand the terms
*Yo, el padre/tutor de* Student Name/*Nombre del/de la Estudiante* *estudiante en la* School/*Escuela* *entiendo los términos*

and conditions of the Extended Day Program. I understand that, if necessary, the above fees will be charged to my account.
*y condiciones del Programa de Día Extendido. Entiendo que, de ser necesario, los cargos arriba mencionados serán cargados a mi cuenta.*

**NON-PAYMENT:** Any child attending two weeks without payment of fees may not be admitted into the program unless this delinquent account is paid in full.
***FALTA DE PAGO:*** *Cualquier niño/a que asista durante dos semanas sin que se hayan pagado los cargos, no se le admitirá dentro del programa a menos que la cuenta atrasada se cancele en su totalidad.*

_____ _____
**Print Parent/Guardian Name / *Nombre del Padre/Tutor en letra de molde*** **Parent/Guardian Signature /*Firma del Padre/Tutor*** **Date / *Fecha***