



STUDY HALL FEE Weekly Rate: \$55.00 Daily Rate: \$12.00
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2011/2012 6th-12th Grade
STUDY HALL REGISTRATION FORM
 *This form must be completed *before* your child stays in Study Hall.

PRINTED STUDENT Name _____

Grade/Homeroom _____

PERSON RESPONSIBLE FOR STUDY HALL PAYMENT
I will be responsible for the above named student and will adhere to the financial policies as stated in the SCS Parent Student Handbook:

PRINTED Name _____

Home Phone _____

Work/Cell _____

I agree by my signature below that the information provided on this form is complete and correct to the best of my knowledge, and I agree to immediately notify the school in writing of any changes.

Signature of person responsible for tuition: (required) _____ Date: _____

Address if different than on reverse: _____

STUDY HALL CLOSES AT 6:00 PM
A late pick up fee of \$3.00 per minute will be charged for each child remaining after 6:00 pm.

You **MUST** list names of responsible family members or friends who, in case of an emergency, may be contacted:

1. Name: _____ Home: _____ Work/Cell: _____

2. Name: _____ Home: _____ Work/Cell: _____

3. Name: _____ Home: _____ Work/Cell: _____

***Please complete the Medical Release Form on the reverse side.**
THIS FORM MUST BE NOTARIZED

SUMMIT CHRISTIAN SCHOOL <i>"Excellence in all things, and all things to God's glory"</i> 4900 Summit Boulevard • West Palm Beach, FL 33415 561.686.8081 • Fax 561.686.1247 • www.summitchristian.com
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Summit Christian School

4900 Summit Boulevard ♦ West Palm Beach, FL 33415 ♦ 561. 686.8081

Medical Release Form

Student Name: _____ Grade: _____

Address: _____ City/State/Zip: _____

Home phone: _____

Sex: Male Female Age _____ Date of Birth _____ Place of Birth: _____

Child lives with Both parents at home Both parents, different homes Mother only Father only Other _____
(Please provide the school with any current legal documentation that pertains to custody issues.)

Mother's Information

Name: _____

Home phone: _____

Work phone: _____

Cell phone: _____

Father's Information

Name: _____

Home phone: _____

Work phone: _____

Cell phone: _____

Name of **Emergency Contact**: _____

Home phone: _____

Family Physician: _____

Relationship to Student: _____

Work /Cell phone: _____

Telephone: _____

Allergies / Medical Conditions / Special Needs: _____

Health Insurance Carrier: _____

Policy #: _____

Does your religion restrict any regular medical practices? If so, please list:

My student may be given the following medication in case of minor headache or discomfort (not applicable for Extended Care):

Tums Aspirin Tylenol Ibuprofen Immodium Pepto Bismol Benadryl None

I authorize Summit Christian School, its officers, directors, employees, managers, and agents or an adult representative of the School to consent to any and all medical and hospital care and treatment as deemed necessary for the health and well-being of my child by a duly-licensed physician selected by said representation. I understand that I shall be fully responsible for, and agree to pay for, all costs and expenses incurred in connection with such medical services rendered to my child pursuant to this authorization. During trips, should it be necessary for my child to return home due to medical reasons or otherwise, I agree to assume all transportation costs.

SIGNATURE of PARENT or LEGAL GUARDIAN: _____

FOR NOTARY PUBLIC:

State of Florida, County of Palm Beach

Sworn to and subscribed before me this _____ day of _____, 20_____.

My Commission Expires:

Notary Public - State of Florida at Large