STEM Academy
Enrollment Application
www.gostemacademy.com

CHILD FIRST & LAST NAME: _____ DOB: _____ AGE: _____ Gender: □ M □ F

Primary Address: _____ City: _____ Zip: _____

Primary Phone Number: _____ Primary Email: _____

Child Primarily Lives with (circle one): Mom & Dad Mom Dad Other (please explain): _____

How did you hear about STEM Academy: _____ Referred by: _____

Registration Date: _____ Start Date: _____ Full Day / Half Day Times: _____

Program (circle one): INFANT TODDLER TRANSITION PRESCHOOL PRE-K KINDERGARTEN 1ST GRADE BEFORE CARE AFTER CARE

If attending public school, which school/times: _____ GRADE: _____ AFTER CARE PACKAGE: 1 2

PARENT/GUARDIAN #1 Name: _____ Circle one: Mom Dad Other: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Employer: _____ Work Phone: _____

Employer's Address:_____

Email/s: _____

PARENT/GUARDIAN #2 Name: _____ Circle one: Mom Dad Other: _____

Address (if different from above): _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Employer: _____ Work Phone: _____

Employer's Address:_____

Email/s: _____

ADDITIONAL CHILD INFORMATION

My child has been in a home/group/private care before: YES NO

My child's primary language spoken at home is _____

Typical bed time and wake up time _____

Number of siblings _____ Birth order of child _____

SPECIAL REQUESTS/NEEDS/CONCERNS – List Below
(comfort items, special words, fears, etc.)

_____

_____

_____

_____

EMERGENCY CONTACTS *(parent/guardian notified first, next in priority)*

Contact #1 Name: _____ Relationship: _____ Phone: _____

Contact #2 Name: _____ Relationship: _____ Phone: _____

Contact #2 Name: _____ Relationship: _____ Phone: _____

AUTHORIZATION OF EMERGENCY MEDICAL TREATMENT *In the event of an emergency requiring a physician's care or 911 to be called. Please read and sign the following:*

I (WE) _____ & _____ PARENTS/GUARDIANS OF
PARENT/GUARDIAN NAME – PRINT **PARENT/GUARDIAN NAME - PRINT**

_____ AUTHORIZE FOR EMERGENCY PURPOSES ONLY, A DESIGNATED EMPLOYEE
CHILD NAME

OF STEM ACADEMY TO TRANSPORT THE ABOVE MINOR CHILD BY AMBULANCE AND CONSENT TO ANY NECESSARY EXAMINATION, ANESTHETIC,

MEDICAL ADVICE AND/OR TREATMENT FROM A PHYSICIAN OR SURGEON LICENSED TO PRACTICE IN THE STATE OF NEW JERSEY.

_____
KNOWN ALLERGIES TO MEDICATION OR FOODS

_____
AUTHORIZATION: SIGNATURE OF PARENT(S) **DATE**

MEDICAL INFORMATION

Does your child have food/seasonal allergies?	YES _____	NO_____
Does your child have an EPI-PEN?	YES _____	NO_____
Does your child have an allergy/asthma action plan?	YES _____	NO_____
Any major illness or physical conditions?	YES _____	NO_____
Will this affect your child's participation in center activities?	YES _____	NO_____
Is your child currently under a physician's care?	YES _____	NO_____
Does your child take prescribed medications?	YES _____	NO_____
Does your child use any special devices (hearing aid, etc.)	YES _____	NO_____
Do you any concerns with your child being in group care?	YES _____	NO_____

If you have selected YES to any of the questions above, please explain:_____

_____

_____

_____

CHILD'S HEALTH CARE INFORMATION

DOCTOR FIRST & LAST NAME: _____ OFFICE PHONE: _____

OFFICE MAILNG ADDESS: _____ FAX PHONE: _____

DENTIST FIRST & LAST NAME: _____ OFFICE PHONE: _____

CHILD FIRST & LAST NAME: _____ DOB: _____ AGE: _____ Gender: □ M □ F

CHILD RELEASE AUTHORIZATION

The names of ANY individuals who are authorized to pick up your child, besides yourself, must be on file here at the center. If anyone else will be picking up your child, please notify the office and use an AUTHORIZATION PICK UP FORM. STEM ACADEMY cannot release your child to anyone not authorized to pick up without written consent.

ALL INDIVIDUALS WILL NEED TO PROVIDE A PHOTO I.D. WHEN PICKING UP.
A COPY OF THIS PHOTO I.D. WILL BE MADE AND KEPT ON FILE AT THE CETNER.

NAME	RELATIONSHIP	ADDRESS	PHONE#
NAME	RELATIONSHIP	ADDRESS	PHONE#
NAME	RELATIONSHIP	ADDRESS	PHONE#

SIGNATURE OF PARENT/GUARDIAN DATE

CHILD LEFT AT CENTER

IF A CHILD IS LEFT **MORE THAN 1 HOUR** AFTER CLOSING AND STEM ACADEMY HAS NOT HEARD FROM OR IS UNABLE TO CONTACT THE PARENT(S) OR THE AUTHORIZED PICK UP PERSONS, WE ARE REQUIRED TO NOTIFY THE LOCAL AUTHORITIES. (NJ 1-877 NJ ABUSE/1-877-652-2873) WE WILL THAN FOLLOW THE INSTRUCTIONS OF LOCAL AUTHORITIES REGARDING YOUR CHILD'S CARE.

PRINT NAME OF PARENT/GUARDIAN SIGNATURE OF PARENT/GUARDIAN DATE

PARENT/GUARDIAN IMPAIRED AT PICK UP

IF THE PARENT/GUARDIAN APPEARS TO BE PHYSICALLY AND/OR EMOTIONALLY IMPAIRED, BY JUDGEMENT OF DIRECTOR/STAFF MEMBER, AND THE CHILD WOULD BE PLACED AT RISK OF HARM IF RELEASED TO THIS PARENT/ GUARDIAN; STEM ACADEMY WILL NOT RELEASE THE CHILD AND AN ALTERNATIVE PICK UP PERSON MUST BE ARRANGED.

PRINT NAME OF PARENT/GUARDIAN SIGNATURE OF PARENT/GUARDIAN DATE

CUSTODY ISSUES/ CUSTODIAL PAPERS

IF THERE ARE ANY CUSTODY ISSUES, COURT DOCUMENTS, DIVORCE AGREEMENTS, VISITATION RESTRICTIONS, DYFS ISSUES REGARDING YOUR CHILD, STEM ACADEMY MUST HAVE A COPY OF THESE PAPERS ARE ON FILE.

_____ NO, THERE ARE NO RESTRICTIONS

_____ YES, THERE ARE SUCH RESTRICTIONS: COPIES HAVE BEEN PROVIDED.

PRINT NAME OF PARENT/GUARDIAN SIGNATURE OF PARENT/GUARDIAN DATE

PARENT AUTHORIZATION PAGE

PARENT PERMISSION FOR SCHOOL PICK-UP AND/OR DROP-OFF

STEM ACADEMY HAS PERMISSION TO TRANSPORT _____, ON A DAILY BASIS (OR ON
PRINT CHILD NAME

DAYS INDICATED) TO/FROM _____ SCHOOL AND TRANSPORT CHILD BACK TO/FROM STEM ACADEMY.
PRINT NAME OF SCHOOL

DAYS INDICATED: _____

_____
SIGNATURE OF PARENT/GUARDIAN **DATE**

PARENT RELEASE OF PRIVATE INFORMATION

_____ YES, WE GIVE PERMISSION FOR OUR ADDRESS/PHONE # TO BE ON THE CLASS LIST.

_____ NO, WE DO NOT GIVE OUR PERMISSION FOR OUR EMAIL ADDRESS/PHONE# TO BE ON THE CLASS LIST.

EMERGENCY MEDICAL RELEASE - This is to certify that I voluntarily furnish medical information on the above designated student to STEM ACADEMY FOR YOUNG KIDS. I hereby request that in the event that emergency medical care for my child. I further give my consent for an emergency medical facility or physician to administer necessary medical treatment to my child if I am unable to be reached or the situation requires immediate attention. I understand that I am responsible for paying all medical bills.

PRINT NAME: _____ **SIGNATURE**: _____ **DATE**: _____

ACKNOWLEDGMENT OF WAIVER AND RELEASE - By signing this form I confirm to pay my tuition fees **AND** I confirm I realize all risks related to the transportation, activity and environment. I confirm waiving, releasing and discharging STEM Academy For Young Kids and its associates from any and all claims of liability or expenses of any kind and/or nature whatsoever arising out of or relating to my child/ren's participation in the Enrichment and Care Programs.

PRINT NAME: _____ **SIGNATURE**: _____ **DATE**: _____

I (WE) HAVE READ AND FILLED OUT TO THE BEST OF MY (OUR) KNOWLEDGE THE ABOVE ENROLLMENT APPLICATION FOR MY (OUR) CHILD FOR ENROLLMENT AT THE STEM ACADEMY FOR YOUNG KIDS.

_____
PRINT CHILD'S NAME DATE

_____
PARENT SIGNATURE DATE

_____
PARENT SIGNATURE DATE

CHILD VISITED CENTER ON: _____

CHILD'S ENROLLMENT DATE: _____

(PRESCHOOL, PRE-K, KINDERGARTEN & FIRST GRADE ONLY)

CHILD ASSESSMENT DONE:_____

ALLERGY/ASTHMA ALERT FORM

Our first priority at STEM Academy is every child's safety. Please complete the information below and speak directly with the Director concerning your child's allergy/asthma action plan if applicable.

Child's Name: _____ GRADE: _____ AGE: ____ Gender: M / F

___ Yes, my child has an allergy/allergies/asthma. If yes, please continue signing and completing this form.

___ No, my child does not have any allergy/allergies/asthma. If no, please sign below.

_____

Parent/Guardian Signature Date

Please list any known ALLERGY/ALLERGIES/ASTHMA below:

_____

_____

_____

Does your child have an allergy and/or allergies?	YES _____	NO _____
Does your child have an epinephrine auto injector (i.e. EpiPen, Auvi-Q)?	YES _____	NO _____
Does your child have an antihistamine such as Benadryl?	YES _____	NO _____
Have you supplied the center with Benadryl and/or an EpiPen? (All prescriptions must be given in its original box with the original label.)	YES _____	NO _____
Does your child have asthma?	YES _____	NO _____
If your child has asthma, does your child have an inhaler?	YES _____	NO _____
Did your doctor fill out an allergy and/or asthma action plan?	YES _____	NO _____

PARENTS OF CHILDREN WITH ALLERGIES MUST DISCUSS ANY/ALL DIETARY ISSUES WITH THE DIRECTOR UPON ENROLLMENT. WE STRONGLY ENCOURAGE PARENTS OF CHILDREN WITH ALLERGIES TO SUPPLY ALL THEIR CHILD'S FOOD AND BOWLS UNLESS OTHERWISE AGREED UPON. ALL CHILDREN WITH SEVERE ALLERGIES AND/OR ASTHMA REQUIRE THE APPROPRIATE EMERGENCY ACTION PLAN AUTHORIZED BY A PHYSICIAN.

_____ _____

Parent/Guardian Signature Date Director Signature Date

PHOTO CONSENT FORM

Child Name: _____ GRADE: _____ AGE: ____ Gender: M / F

_____ **Yes, I do give my consent** to STEM Academy to use photo or video images taken of my child in school brochures, advertisements for the school, on the website, in social media and in other school publications as they see fit. I agree to hold harmless STEM for Young Kids from any liability which may result from the use of said picture(s). This form will apply throughout my child's tenure at STEM Academy for Young Kids and will not need to be updated unless I so desire.

_____ **Yes, with the following limitations** listed below – if none apply, please use N/A.

_____

_____

_____

_____ **No, I do not give my consent** to STEM Academy to use pictures taken of my child in school brochures, advertisements for the school, on the website, in social media and in other school publications as they see fit.

Name of Parent/Guardian (print): _____

Signature of Parent/Guardian: _____

Date: _____

INFO TO PARENTS SIGN OFF PAGE

Dear Parent/Guardian:

As per New Jersey Child Care Center Licensing Requirements, we are obliged to provide you, as the parent/guardian of a child enrolled at our center, with this informational statement.

The statement highlights, among other things: your right to visit and observe our center at any time without having to secure prior permission; the center' s obligation to be licensed and to comply with licensing standards; and the obligation of all citizens to report suspected child abuse/neglect/exploitation to the State Central Registry Hotline (877) NJ ABUSE (877) 652-2873.

Please read this statement carefully, and if you have any questions, feel free to contact me at:

732-243-9793 or info@gostemacademy.com

Sincerely,

Director
STEM Academy for Young Kids

Please complete and return this portion to the center.

(Please Print)

Name of Child: _____

Name of Parent(s)/Guardian(s):_____

I have received and read a copy of the Info to Parents statement prepared by the Office of Licensing, Child Care & Youth Residential Licensing, in the N.J. Department of Children and Families.

Signature: _____ Date: _____

POLICY AGREEMENT

SCHOOL CLOSINGS & EARLY CLOSING **Initial: _____**

New Year's Day, President's Day, Good Friday, Memorial Day, July 4th, Labor Day, Thanksgiving & the day after, Christmas Day. Early closings: the day before Thanksgiving at 4pm, Christmas Eve at 1pm, New Year's Eve at 4pm.

**Tuition is NOT adjusted for scheduled days off, emergency closings/weather and/or child absence due to illness.*

SECURITY DEPOSIT & ENROLLMENT CONTRACT **Initial: _____**

Upon enrollment, you agree to an initial contract of 3 months of enrollment. This allows your child a proper introduction to the STEM Academy curriculum. This includes a one month security deposit, plus a $100 registration fee (non-refundable). This secures enrollment.

TUITION **Initial: _____**

Tuition is due by the 25th of every month, electronic debit only. If tuition is not received by this date, a $50 late fee will be applied to your account. If tuition is not received by the 30th of the month, care will be suspended until all fees are paid in full.

SUMMER CAMP TUITION **Initial: _____**

Infants and toddlers remains monthly while children 3 years and older will have the option to choose their summer camp weeks. Tuition will be based on a weekly price. More information will be available in the Spring.

SIBLING DISCOUNTS **Initial: _____**

Families with more than one child enrolled at the same time will receive a sibling discount of 10% off the least expensive tuition. Families who enroll 3 or more will receive 10% off the second child and 20% off the third child. Discounts will be applied from the least expensive tuition. Tuition discount offers may not be combined and may not be applicable to all programs.

BREAKFAST/SNACKS **Initial: _____**

Snacks are served at 8:30am, 3pm, and 5pm. STEM offers dry cereal for breakfast. In the afternoon and early evening, STEM offers fresh fruit and/or dry snacks. Although we are a peanut/tree nut free facility, parents of children with food allergies are expected to contact the office in order to agree upon the child's snack.

LUNCH **Initial: _____**

Lunch may be purchased for an additional $6 per day. You may pick and choose the days you would like to order. Lunch includes a main entrée, a side & milk or water. If you do not purchase lunch, you must provide your child with a peanut/tree nut free lunch. If lunch is not provided, lunch will be purchased at a cost to you of $6. More details in the parent handbook.

WITHDRAWAL POLICY **Initial: _____**

If you plan to withdraw your child from STEM Academy, you must provide a 45 day written note/email stating the child's last day. STEM Academy has the right to charge you one (1) month tuition for not properly giving advanced notice (unless an emergency arises and proof is provided).

BACK TO SCHOOL NIGHT/PARENT/TEACHER CONFERENCE **Initial: _____**

Families with children 3 years and older will have the opportunity to attend our Back to School Night. During the school year, STEM Academy will offer 2 formal parent/teacher conferences. Signup sheets will be made available 2 weeks prior. If at any time the family or the teacher would like to request a meeting, please feel free to contact the teacher/family.

SUMMER CAMP/HOLIDAY BREAKS **Initial: _____**

STEM Academy will offer summer camp from the first Monday after the last scheduled school day until the last week in August. Summer camp is a separate enrollment with an additional cost.

OUTSIDE TIME **Initial: _____**

Children who attend school at STEM Academy are expected to be able to fully participate in the daily schedule which includes outside time and are expected to play outside according to state childcare regulations. Any child who has requested to not participate in outside activity due to weather or illness should remain home until they are able to fully participate.

SICK POLICY **Initial: _____**

As per the parent handbook if your child has any of the following symptoms, they will be excluded from care during such time: children with a fever of 101 Degrees Fahrenheit or higher; brown/green/yellowish discharge from eyes, nose and/or ears; vomiting and/or diarrhea for any length of time. Any child who is out sick for 3 days or longer requires a doctor's note to return. Flu Shots are required by NJ State Regulations.

PARENT HANDBOOK **Initial: _____**

STEM Academy for Young Kids Parent Handbook is located online for your convenience. If you should want a hardcopy, please feel free to ask the Director.

_____

Administration Signature Date

PARENT

RECEIPT OF INFORMATION

Please check the following and complete the bottom portion prior to submitting:

- ☐ Parent Handbook
- ☐ Policy on the Release of Children (N.J.A.C. 10:122-6.5)
- ☐ Sick Policy
- ☐ Policy on Communicable Disease Management
- ☐ Positive Guidance and Discipline Policy and Biting Policy
- ☐ Expulsion Policy
- ☐ Diaper Changing and Potty Training Policies
- ☐ Policy of Methods of Parental Notification
- ☐ Policy of the Use of Technology and Social Media
- ☐ Policy on Methods of Parental Notification
- ☐ DCFS: Information to Parents

I have read and received a copy of the information, policies and parent handbook listed above, and I do have access to admin/director anytime to clarify any and all policies.

Child's Name

Parent/Guardian's Name

Parent/Guardian Signature Date

APPENDIX H

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)* *(First)*	Gender ☐ Male ☐ Female	Date of Birth / /

Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier

Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:		
	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due: _____

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860. The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions -** Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   b. **Medications -** List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

      PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration. *Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*

   c. **Limitations to physical activity -** Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. **Allergies/Sensitivities -** Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. **Emergency Plans -** May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.

Automated Payment Processing
Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express® — a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) _____ **to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. _____ *(initial)* Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

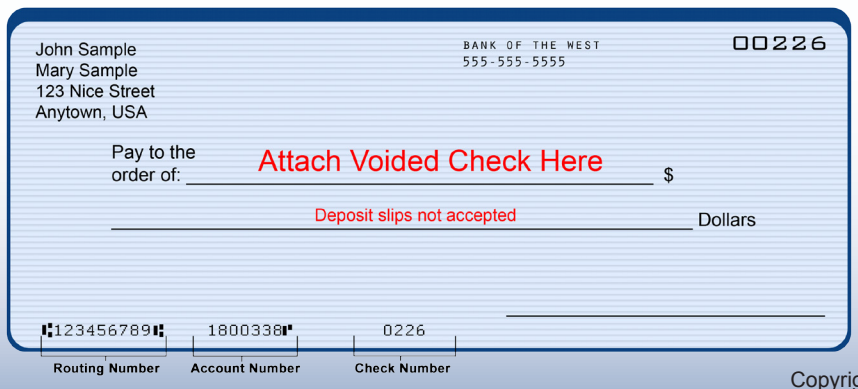
Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____

For Official Use Only

Date Received
Employee Signature



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