



**SUMMER CLUB REGISTRATION -SCHOOL AGE**  
**(5 Weeks – Monday thru Friday)**

Student's name \_\_\_\_\_

New student (Referred by: \_\_\_\_\_)  Current student  Former student

**PLEASE CHECK HERE IF ALL CONTACT INFORMATION IS THE SAME AS PREVIOUS**  
(If checked above, you do not need to fill out contact info again below in box)

Nickname: \_\_\_\_\_ Gender: M F Age \_\_\_\_\_

Parents' name \_\_\_\_\_

Phone #: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Email address (main) \_\_\_\_\_

Email address (secondary) \_\_\_\_\_

**Session:**  July 9-13  July 16-20  July 23-27  July 30-Aug.3  Aug. 6-10

**Length:**  M, W, F (3 days)  M-F (5 days)

Language to be learned = **Spanish**

How motivated is your child to attend the program? 0 1 2 3 4 ?  
(Circle a number or question mark) (not) (very) (don't know)

If you circled the question mark, please explain \_\_\_\_\_

Are one/both parents able to read some Spanish?  Yes  No

Are one/both parents able to speak some Spanish?  Yes  No

School child currently attends: \_\_\_\_\_

Grade your child is in: K 1<sup>st</sup> 2<sup>nd</sup> 3<sup>rd</sup> 4<sup>th</sup> 5<sup>th</sup> 6<sup>th</sup> 7<sup>th</sup>

Enclosed please find \$ \_\_\_\_\_  check # \_\_\_\_\_  cash

\_\_\_\_\_ Date \_\_\_\_\_  
Signature of parent or guardian

**For Office Use Only**

Class ID \_\_\_\_\_ Instructor \_\_\_\_\_  
Entered in Add. B. G\_ I\_C\_ Exc. C. \_\_\_\_\_ Exc. D. \_\_\_\_\_ Inv # \_\_\_\_\_ and date sent \_\_\_\_\_  
Target completion date for class \_\_\_\_\_  
Forms received in person \_\_\_\_\_ by mail \_\_\_\_\_ Date \_\_\_\_\_



**CHILD'S PERSONAL DATA SHEET**

Today's Date: \_\_\_\_\_

**1. NAME OF CHILD** \_\_\_\_\_ **BIRTH DATE** \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

**Mother's name** \_\_\_\_\_

Phone #: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Email address \_\_\_\_\_

Employer \_\_\_\_\_ Work hours \_\_\_\_\_

**Father's name** \_\_\_\_\_

Phone #: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Email address \_\_\_\_\_

Employer \_\_\_\_\_ Work hours \_\_\_\_\_

Why do you want your child to learn a second language? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If we have to change the existing schedule what other day and time would you prefer?

Day \_\_\_\_\_ Time \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

Signature of parent or guardian



**2. OTHER CONTACT IN CASE OF EMERGENCY:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone #s: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Is this person authorized to take the child from the center? Yes  No

**List all other adults who are authorized to take the child from the center:**

_____ Name	_____ Relationship	_____ Name	_____ Relationship
_____ Address		_____ Address	
_____ City	_____ State	_____ City	_____ State
_____ Zip		_____ Zip	
_____ Phone		_____ Phone	

**3. MEDICAL INFORMATION:**

Child's Physician or emergency treatment facility \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

I, \_\_\_\_\_ (father/mother/guardian) of \_\_\_\_\_ (Child's name) do hereby give my consent to the Director of Larson's Language Center, or her duly appointed representative, for said child to receive medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician or surgeon in case of an emergency when the parents cannot be reached. Consent is also given for the director or her duly appointed representative to transport said child for emergency medical treatment, if the parents cannot be reached.

Signature (X) \_\_\_\_\_ Date \_\_\_\_\_

Witness (X) \_\_\_\_\_ Date \_\_\_\_\_

I hereby give \_\_\_ /do not give \_\_\_ the Director of the Larson's Language Center, or her appointed representative permission to give \_\_\_\_\_ (Child's name) acetaminophen. I understand I will be notified that the medication has been administered.

Signature (X) \_\_\_\_\_ Date \_\_\_\_\_



**4. IMMUNIZATIONS:** Please provide a copy of your Child's Immunization Records. (If your child is in one of our programs held outside of our school, we do not need Immunization Records)

Verified by Health Department Record \_\_\_\_\_ Physician's Record \_\_\_\_\_ Other \_\_\_\_\_

**5. DISEASE HISTORY: LIST THE DATES OF EACH:**

Measles \_\_\_\_\_ Mumps \_\_\_\_\_ German Measles \_\_\_\_\_

Chicken Pox \_\_\_\_\_ Whooping Cough \_\_\_\_\_

Contracted Tuberculosis: Yes \_\_\_\_\_ No \_\_\_\_\_ Frequent Ear Infections: Yes \_\_\_\_\_ No \_\_\_\_\_

Frequent Throat Infection: Yes \_\_\_\_\_ No \_\_\_\_\_ Defective Heart: Yes \_\_\_\_\_ No \_\_\_\_\_

Other Conditions or Comments \_\_\_\_\_

**6. CHILD'S DEVELOPMENTAL NEEDS:**

**Physical or emotional problems the child might have:**

\_\_\_\_\_

**Child's special food needs:** Formula \_\_\_\_\_ Diabetic diet \_\_\_\_\_

**ALLERGIES** \_\_\_\_\_

**Special problems:** Medications \_\_\_\_\_

**ALLERGIES** \_\_\_\_\_ Temper Tantrums \_\_\_\_\_ Diabetes \_\_\_\_\_ Frequent colds \_\_\_\_\_ Biting \_\_\_\_\_ Sun

Sensitivity \_\_\_\_\_ Seizures \_\_\_\_\_ Fainting Spells \_\_\_\_\_ Bed wetting \_\_\_\_\_

Other \_\_\_\_\_

**Favorite:** Games \_\_\_\_\_ Toys \_\_\_\_\_ Foods \_\_\_\_\_

**Siblings:** Yes \_\_\_\_\_ No \_\_\_\_\_ Name(s) \_\_\_\_\_

**Other useful information:** \_\_\_\_\_

**Does your child require help in:**

Dressing \_\_\_\_\_ Un-dressing \_\_\_\_\_ Toileting \_\_\_\_\_ Eating \_\_\_\_\_ Washing hands \_\_\_\_\_

Is child toilet trained? \_\_\_\_\_ Words used in toileting \_\_\_\_\_

Type of child care used before: \_\_\_\_\_

**Does your child take a nap?** \_\_\_\_\_ At what time? \_\_\_\_\_ For how long? \_\_\_\_\_

**7. I, the parent or guardian of this child, understand that I may ask for a conference with the Director and/or instructors as needed.**

\_\_\_\_\_ Date \_\_\_\_\_

Signature of parent or guardian

Additional comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**AGREEMENTS BETWEEN LARSON'S LANGUAGE CENTER  
AND THE STUDENT'S PARENT**

I, \_\_\_\_\_ parent of \_\_\_\_\_  
who is studying \_\_\_\_\_:

1. Agree that student will be encouraged to participate in various activities outside of class where the second language is involved; for example, viewing TV programs and videos, using library programs, computer programs and books.
2. Agrees to notify Larson's Language Center prior to class start time via e-mail or telephone if the student is unable to attend school/program, even if the notification is "last minute".
3. Agree that when Larson's Language Center is closed for weather or other unforeseen reason, the classe(s) will be made up at a later date.
4. Agree to notify Larson's Language Center within one week of the final class as to whether or not student will attend the NEXT SESSION (Summer Club).
5. Agree that the **registration fee** is NOT refundable, and **tuition** is ONLY refundable **3 weeks prior** to the start date.
6. Agree that if you make payments, you are still responsible for the entire cost of Tuition. Consecutive payments are due by the first day of the following months.

**The signing of this agreement indicates that everything is well understood.**

\_\_\_\_\_ Date: \_\_\_\_\_  
 Signature of parent or guardian



**PARENT'S CONSENT FOR PHOTOGRAPHY**

Do we have your permission to include your child or children in photos or videos for TV or Newspaper coverage of our programs, or for promotional purposes? Yes No

I \_\_\_\_\_ will allow Larson's Language Center to include my child, \_\_\_\_\_ in photographs or videotape documenting our program activities for informational or promotional purposes.

\_\_\_\_\_ Date: \_\_\_\_\_

Signature of parent or guardian

**OUR DISCIPLINE POLICY**

Larson's Language Center uses the following methods of discipline:

- RULES ARE ESTABLISHED FOR THE BENEFIT OF THE CHILDREN
- POSITIVE RE-ENFORCEMENT WILL BE USED
- RE-DIRECTIONS WILL BE GIVEN TO THE CHILDREN.
- IF INAPPROPRIATE BEHAVIOR CONTINUES, A TIMEOUT MAY BE USED.

I have read and understand the discipline policy of Larson's Language Center. I give my permission for the use of all methods set out above.

\_\_\_\_\_ Date: \_\_\_\_\_

Signature of parent or guardian

If the parent or guardian disagrees with any disciplinary method above, please list method preferred:

\_\_\_\_\_ Date: \_\_\_\_\_

Signature of parent or guardian

PLEASE NOTE: Physical punishment shall not be administered to children.  
(Minimum Licensing Requirements for Child Care Centers 500.2)  
(Minimum Licensing Requirements for Day Care Family Homes 501.1)

**CHILD INTERVIEWS**

In accordance with Arkansas Department of Health and Human Services, Division of Child Care and Early Childhood Education, Child Care Licensing Unit licensing requirements:

"Parents shall be informed in writing upon enrollment of their children that children may be subject to interviews by licensing staff, child maltreatment investigators and/or law enforcement officials for the purpose of determining licensing compliance or for investigative purposes. (Child interviews do not require parental notice or consent.)"

Sign here to indicate that you have read the preceding statement.

\_\_\_\_\_ Date: \_\_\_\_\_

Signature of parent or guardian