

PAFEA After-School Program Enrollment Form (N) 2019-20

Parent/Guardian Name					
Parent/Guardian Name					
Address					
City		Zip Code		Home Phone	
E-mail Address				Cell Phone	
Business/Company Name				Work Phone	
Business Address					
Child's Name		Date of Birth		Grade 2019-20	
<p style="text-align: center;"><u>Annual tuition</u></p> <p style="text-align: center;">\$3,650 by May 1st, 2019</p> <p style="text-align: center;">Included the \$50,00 Non-refundable application processing fee (per child) for new student. Due upon submitting this application. (Waived for continuing PAFEA students)</p>	<p style="text-align: center;"><u>Please choose payment option</u></p> <p style="text-align: center;"><input type="checkbox"/> One payment by May 1st, 2019. \$3,600 + \$50 = <u>\$3,650</u></p> <p style="text-align: center;"><input type="checkbox"/> 2 payments: \$1,900 +\$50 (\$1,950) by May 1st 2019. \$1,950 by Sept. 1st 2019 Total: <u>\$3,900</u></p> <p style="text-align: center;"><input type="checkbox"/> 3 payments: \$1,400 +\$50 (\$1,450) by May 1st 2019. \$1,450 by Sept. 1st 2019. \$1,400 by Jan. 10th 2020. Total: <u>\$4,300</u></p>				
<p>The following individuals are authorized to pick up my child or children from PAFEA classes (please include relationship to child):</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>Does your child have any learning disabilities or require any accommodations to facilitate his or her participation in the PAFEA program? If so, please explain:</p>					

Emergency Contact Information	Address	Telephone number(s)	Relationship to Child	E-mail Address
1. Name:				
2. Name:				
3. Name:				
Child's Physician	Address	Telephone number	Does your child take any medications or have any allergies? If so, please list:	Does your child have any medical conditions or physical limitations? If so, please describe:
Insurance Provider/ Number				
Child's Dentist	Address	Telephone number		
Dental Insurance Provider/ Number				

In the event that your child requires urgent or immediate medical or dental care, you consent to PAFEA or its teachers contacting your child's physician or dentist or, if necessary, transporting or arranging for your child to be transported to the nearest facilities for appropriate treatment.

I acknowledge, by my signature below, that all of the information on this form is current and complete and that I consent to the above provisions regarding urgent medical or dental care for my child. Please sign below and return this Enrollment Form, together with your payment. **Tuition is not refundable.**

Please make your check payable to the Palo Alto French Education Association at:

**PAFEA
P.O. Box 60932
Palo Alto, CA 94306-9991**

Signature: _____

Date: _____