

Prep EX!

DC Prep's Extended Learning Program

Enrollment Application Form

2016-17 School Year

Legal Guardian 1: First	Last	Best Contact #: Type: Home / Work / Cell	Second Phone #: Type: Home / Work / Cell
Legal Guardian 2: First	Last	Best Contact #: Type: Home / Work / Cell	Second Phone #: Type: Home / Work / Cell
Relationship to Student:		Email Address:	

Please list information below for all students who will attend Prep EX!

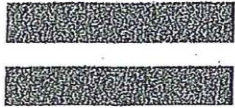
Student Name: First	Last	Grade (2016-17 SY):	Campus:
Student Name: First	Last	Grade (2016-17 SY):	Campus:
Student Name: First	Last	Grade (2016-17 SY):	Campus:
Student Name: First	Last	Grade (2016-17 SY):	Campus:

PAYMENT INFORMATION (Choose one)

- _____ **Full Price** I pay full price of \$180 a month. I will submit my September payment **after August 2nd**
- _____ **Subsidy** I will submit a voucher to subsidize some or all of the *Prep EX!* fees **after August 15th**. I agree to pay any co-pays assigned to me by the Child Care Subsidy Program.
- _____ **Sibling Rule** My child at the Middle Campus is enrolled in Prep Hour until 5:00. My child at the elementary campus will participate in *Prep EX!* free of charge until my middle-schooler is dismissed.
- Name of middle-schooler: _____ Grade: _____

Applications will be accepted on a space-available basis. Please submit completed forms, payments, and vouchers to the Front Desk.

Students with outstanding Prep EX! balances from last school year must settle their account before enrolling.



Office of the
State Superintendent of Education

PLEASE TYPE OR PRINT

AUTHORIZATION FOR CHILD'S EMERGENCY MEDICAL TREATMENT

If my child _____, born on _____, becomes ill or involved in an accident and I cannot be contacted, I authorize the following hospital or physician to give the emergency medical treatment required:

Hospital: _____

Address: _____

or:

Physician: _____ M.D. Telephone No: _____
(Area Code)

Address: _____

I give permission to _____, located at
Name of Facility or Caretaker
_____, to take my child for treatment.

I accept responsibility for any necessary expense incurred in the medical treatment of my child, which is not covered by the following:

Health Insurance Company: _____

Name of Policy Holder: _____ Relationship to Child: _____

Policy Number: _____ Coverage: _____

Medicaid Number: _____ State: DC MD VA

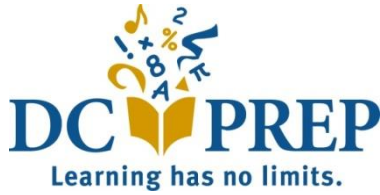
Child's Known Allergies or Physical Conditions: _____

Signature: _____ Relationship to Child: _____

Address: _____

Telephone No: _____
Home Business Pager/Cell Phone

Date: _____ Date Updated: _____
Month/Day/Year Month/Day/Year



DC PREP
Learning has no limits.
Prep EX!
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2016-17 SCHOOL YEAR HANDBOOK CONFIRMATION FORM

Please **clearly** print your name and sign the following form, prior to turning it in with your child's campus front desk Operations Assistants,

I, _____, have reviewed the 2016-2017 **Prep EX!** and agree to the rules and procedures it contains.

Student Name: First Last	Grade (2016-17 SY):	Campus
Student Name: First Last	Grade (2016-17 SY):	Campus:
Student Name: First Last	Grade (2016-17 SY):	Campus:
Student Name: First Last	Grade (2016-17 SY):	Campus:

Signature: _____

Date: _____