

TELC Summer Fun Days Registration Form 2021

Please circle the days you would like for your child to attend.

June 1 st , 2 nd , 3 rd	Tuesday	Wednesday	Thursday
June 15 th , 16 th , 17 th	Tuesday	Wednesday	Thursday
July 13 th , 14 th , 15 th	Tuesday	Wednesday	Thursday
July 20 th , 21 st , 22 nd	Tuesday	Wednesday	Thursday
August 3 rd , 4 th , 5 th	Tuesday	Wednesday	Thursday

*\$50 per day/ \$150 per week. An auto draft form is required to be completed at the time of registration. If you already have an auto draft form on file, we will use that unless you notify us of a change in account. Your first 3 days will be auto drafted in the amount of \$150 at the time of registration. This secures your child's spot. For subsequent summer weeks, accounts will be drafted on the Tuesday of each summer fun week. Payments in full are accepted. Your account will be charged for the first 3 days when registering for 3 or more days. If registering for less than 3 days, your account will be charged the full amount. Decline and NSF fees apply. **Payments will not be refunded for missed days. However, you can call to schedule a makeup day if there is availability. You must cancel registered days prior to the Tuesday of a summer fun week.**

****Please attach the health information page with physician signature if not currently enrolled in TELC.****

Child's Name: _____

Child attended TELC during school year
2020-2021: YES or NO

Child's DOB: _____

Does your child have a diagnosed food allergy?

Parent or Legal Guardian Name: _____

_____ * Yes _____ No

*If yes, emergency plan required. Submitted on _____

Phone Number: _____ Email: _____

Home address: _____

Emergency Contact: **(Please print first and last name, relationship, and phone number.)**

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the TELC Director and/or Assistant Director or person in charge to contact my child's physician or transport my child to the nearest hospital. I give consent for necessary emergency treatment when my child is in the care of this physician and/or a hospital.

Parent Signature _____ Date _____

Name of Licensed Physician _____ Phone # _____

Address of Physician or Clinic _____

Office Use Only:

Current TELC student Y or N

Regis. Date _____ Health Info page _____

Auto Draft Form _____ Checking _____ CC

Initial Payment amount _____ Date _____

Payments:

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