STAR NOVA REGISTRATION (2013-2014)

SCHOOL NAME:_____ NOVA SESSION (circle one) 1 2 3 4

CHILD'S NAME:_____ Room #_____ Grade:_____

Age:_____ Birthdate: _____/_____/_____ Sex: M_____ F_____ Home Language_____

Home Address:_____City:_____Zip:_____

Home Phone#:_____Home E-Mail Address:_____

Parent/Guardian1:_____Cell#_____

Employment:_____Position:_____

Address:_____City:_____Zip Code:_____

Parent/Guardian2:_____Cell#_____

Employment:_____Position:_____

Address:_____City:_____Zip Code:_____

In addition to the individuals listed above, the following people have my permission to pick up my child.

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

PLEASE INDICATE ETHNICITY (OPTIONAL) ☐American Indian/Alaskan Native ☐Asian ☐Hispanic
☐Black (not of Hispanic origin) ☐White (not of Hispanic origin) ☐Filipino ☐Pacific Islander ☐Other_____

Class	Day	Time	Fee
	M T W Th F		$.
	M T W Th F		$.
	M T W Th F		$.
	M T W Th F		$.
	M T W Th F		$.

☐ *Check here if your child attends an afterschool program and list it here please_____.*

***Nova Registration Fee**	$	10.00
Subtotal	$	
Grand Total	$	

CREDIT CARD PAYMENT OPTION: Name on Card:_____Visa ___ MC ___

Credit Card #_____ Exp:_____ CVV#_____

Billing Address: _____Authorizing Signature:_____

RELEASE OF LIABILITY

I hereby agree to hold harmless STAR Inc., STAR Staff, Directors, Administrators and Members of the Board of Directors from any liability related to any and all STAR activities and programs. I hereby acknowledge the existence of the implied risk associated with all programs for children and the areas where such activities and programs take place.

STAR POLICIES: PHOTOGRAPHY, VIDEO CONSENT, BEHAVIOR AND MEDICAL INFORMATION

In case of actual emergency STAR will make every effort to contact the parents of the child involved before any treatment is administered; however in the event we are unable to make contact with you, the parents, we require this medical release to be signed by all participants.

I HEREBY AUTHORIZE THE PHYSICIAN OR HOSPITAL SELECTED BY STAR TO HOSPITALIZE OR SECURE TREATMENT FOR AND TO ORDER INJECTION, ANESTHESIA, AND/OR SURGERY FOR MY CHILD.

ANY KNOWN ALLERGIES?_____

PHYSICIANS NAME:_____ PH#_____

PARENTS SIGNATURE:_____ DATE:_____

PARENTS PLEASE READ THE ENROLLMENT PROCEDURE PAGE OF THIS BROCHURE CAREFULLY BEFORE REGISTERING YOUR CHILD.

BY SIGNING THE APPLICATION YOU ARE ACCEPTING THESE CONDITIONS, THANK YOU.

See your STAR Director for a scholarship application. In order to be considered you must submit this application 1 week before the session begins.

FOR STAR USE ONLY:

Date Chk# Amount Paid Balance Due

Nova Only & G4 Schools