



*Over 30 years of helping learners learn*

**2011-2012 REGISTRATION**

**STUDENT INFORMATION**

<b>Student's Last Name</b>		<b>Student's First Name</b>		Preferred Name
Birthdate		Email		
Gender: ( ) Male ( ) Female		Grade	School	
( ) Adult ( ) Child		SIN # (for Adult students only)	EM# (for GT Hiring Solution Clients only)	
Parent(s)/Guardian(s) Name				
Phone (home) ( )		Phone (work) ( )		Phone (cell) ( )
Street Address		City		Postal Code
Sponsor (if applicable)		Sponsor phone ( )		Sponsor fax ( )
Sponsor Email				

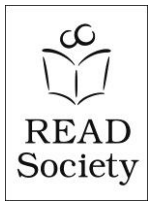
**CONTACT INFORMATION**

(During the time the student is at READ)

PARENT/GUARDIAN #1: Last Name, First Name	Day time phone ( )	Night time phone ( )	Cell /other ( )
PARENT/GUARDIAN #2: Last Name, First Name	Day time phone ( )	Night time phone ( )	Cell /other ( )
EMERGENCY CONTACT #1: Last Name, First Name	Relation to student	Day time phone ( )	Night time phone ( )
EMERGENCY CONTACT #2: Last Name, First Name	Relation to student	Day time phone(s) ( )	Night time phone ( )
WHO HAS LEGAL CUSTODY OF THIS STUDENT: ( ) Parent/Guardian #1 ( ) Parent/Guardian #2 ( ) Both ( ) N/A ( ) Other _____			

**ASSESSMENT APPOINTMENT: FOR OFFICE USE ONLY**

( ) Full Assessment \$160 ( ) Assessment n/a ( ) Consultation \$60 per hour			
Assessment Date	Time	( ) LA ( ) Math	( ) Quadra ( ) Sidney
Teacher		Notes	



### STUDENT'S MEDICAL INFORMATION

(please attach additional pages if necessary)

Student's Last Name	Student's First Name
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STUDENT'S BC CARE CARD PERSONAL HEALTH NUMBER (or equivalent) 

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**FAMILY DOCTOR**

Name	Phone
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**DOES YOUR CHILD HAVE ANY ALLERGIES?**

Food: <input type="checkbox"/> YES <input type="checkbox"/> NO	Other Allergies (medicinal, environmental, etc.): <input type="checkbox"/> YES <input type="checkbox"/> NO
Please specify:	

**DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HEALTH OR MEDICAL ISSUES?**

Asthma     Diabetes     Seizures     Hearing loss     Fainting     Skin conditions  
 Heart conditions     Urinary tract infections    Describe \_\_\_\_\_  
 Other (please specify) \_\_\_\_\_

**IMMUNIZATIONS:**

<input type="checkbox"/> Polio: date _____	<input type="checkbox"/> Diphtheria: date _____
<input type="checkbox"/> Whooping cough: date _____	<input type="checkbox"/> Tetanus: date _____

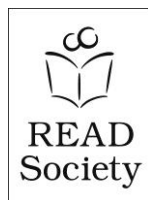
**DOES THIS STUDENT TAKE MEDICATIONS REGULARLY?**

YES     NO    IF YES, PLEASE SPECIFY BELOW:

MEDICATION NAME	DOSAGE	TIME(S) OF THE DAY
EXAMPLE: amoxicillin	250mg – 3 times/day	8:30am, 1:30pm and 6:30pm

**IN THE CASE OF AN EMERGENCY: FOR OFFICE USE ONLY**

This student was released to (please print) \_\_\_\_\_  
 on (date) \_\_\_\_\_ at (time) \_\_\_\_\_  
 Signature (of the person this student was released to) \_\_\_\_\_



## PROGRAMS AND SERVICES

Programs and Services	Fees
Adult Classes	\$40.00 per hour
Adult Private Classes	\$60.00 per hour
Assessment, full	\$160.00
Children and Youth Classes	\$40.00 per hour
Children and Youth Private Classes	\$60.00 per hour
Consultation	\$60.00 per hour
Noisy Kids Reading Club (Summer)	\$125.00 per week (9 a.m. -12 p.m. M-F)
Other	\$

### POLICIES

#### Program/Class Scheduling

- Classes are scheduled for a minimum of 3 months.
- Students can miss one class out of every 12 classes on sick or compassionate grounds.

#### Program/Class Cancellation

- The READ Society reserves the right to cancel classes/programs due to limited registration.
- An automatic credit will be given for classes cancelled by READ.

#### Refunds and Withdrawal

- The READ Society requires **fifteen days written notice** to withdraw students unless withdrawal is at the advice of his/her READ teacher.
- Pro-rated refunds are available when written notice is provided.

#### Payment

- All programs/services must be **pre-paid**. Classes to be **pre-paid monthly before the 1<sup>st</sup> of each month**.
- Payment can be made by cash, cheque, money order, VISA or Mastercard.
- Classes may be suspended for non-payment.
- Late Payment Fees equal to 1.5% of any past due balance are charged if the balance is not paid within 31 days of the invoice date.

#### Pick-up and Drop-off

- The READ Society is responsible for students **during class time only**.
- Students must be picked up on time by a pre-approved designated person.

#### Attendance:

- **Consistent attendance** is vitally important to your child's progress.
- Students must arrive **on time** for their scheduled class.
- If your child misses a class and we have not heard from you, we will contact you before the next class.

#### Privacy

- The READ Society collects personal information in order to provide literacy services and programs for children, youth and adults. This information is collected over the phone, in person, by mail, email, fax or via the website. From time to time general information is used by the Society for planning and funding purposes. Personal information is kept secure and is not released without prior written approval by the individual or guardian.

<b>PAYMENT METHOD</b>				
<input type="checkbox"/> Cash	<input type="checkbox"/> Post-dated cheques	<input type="checkbox"/> Money order	<input type="checkbox"/> VISA	<input type="checkbox"/> MasterCard
Card number _____ - _____ - _____ - _____				Expiry date /
Card holder's name		Card holder's signature		
Monthly statement of READ account to be sent to (name of parent/guardian)				
Monthly statement of READ account to be sent via <input type="checkbox"/> regular mail <input type="checkbox"/> email to this address:				

**I have read and understand the policies and agree to the pre-payment of fees.**

Signature \_\_\_\_\_ Date \_\_\_\_\_



**PROGRAM SCHEDULE: FOR OFFICE USE ONLY**

**Name of Program:**

- |  |   |
|--|---|
| <input type="checkbox"/> Adult Classes         | <input type="checkbox"/> Children and Youth Classes         |
| <input type="checkbox"/> Adult Private Classes | <input type="checkbox"/> Children and Youth Private Classes |
| <input type="checkbox"/> Assessment, full      | <input type="checkbox"/> Consultation                       |
| <input type="checkbox"/> Other _____           | <input type="checkbox"/> Noisy Kids Reading Club            |

Date:	Area of focus: <input type="checkbox"/> L/A <input type="checkbox"/> Math <input type="checkbox"/> Other(s) _____
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Assessment/Consultation Date	Assessor/Teacher
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Program Teacher:	Location: <input type="checkbox"/> Colwood <input type="checkbox"/> Quadra <input type="checkbox"/> Sidney
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Program Start Date:	Program End Date:
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Returning Student:  Yes     No

Program Schedule, day(s) and time(s)

Comments/Notes:	<b>Copied to:</b> <input type="checkbox"/> Client <input type="checkbox"/> Teacher <input type="checkbox"/> A/R <input type="checkbox"/> Other _____
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