



Before & After School Cultural Enrichment Program @ City Neighbors

Showing holistic excellence and healing through
cultural arts and education.



Create an enriching experience to compliment your childs school day!

Locations:

City Neighbors Charter School
4301 Raspe Avenue
Balitmore, MD 21206

City Neighbors Hamilton
5609 Sefton Avenue
Baltimore, MD 21214

- Homework Assistance
 - Visual Arts
 - Foreign Language
 - Dance and Movement
 - Drums and Instruments of the World
 - Poetry & Creative Writing
 - Engineering
 - Multimedia and Film
- Free Time and so much more!

**\$10 EARLY BIRD DISCOUNT FOR REGISTRATION AND FIRST MONTH PAYMENT
RECEIVED BY AUGUST 1st!**

Return Completed Forms with 1st Month's Payment to School Office By August 15th

Monday - Friday

Before School 7:00am - 8:00am

After School 3:00pm - 6:30pm, Wednesday 1:00pm - 6:30pm

For More Information Contact:

443-759-4285 office

443-759-4286 fax

info@oneworld4art.org

www.oneworld4art.org

EMERGENCY AND MEDICAL INFORMATION

IN CASE OF EMERGENCY

Name _____ Relationship: _____

Phone Number during school/camp hours: () _____

Name _____ Relationship: _____

Phone Number during school/camp hours: () _____

The following persons **ARE** allowed to pick up my child:

1. _____
Name Relationship

2. _____
Name Relationship

_____ My child has permission to go home on his/her own at the close of the program

Medical and Immunization Information:

Physician's Name: _____ Phone Number _____

Do you have health insurance? _____ Yes _____ No

Has your child been immunized? _____ Yes _____ No

Does this participant have any illness, medical problems or disabilities that may interfere with dance/sports related physical activity?

No _____ Yes _____ If yes, describe _____

Special dietary needs Explain. _____

RELIGIOUS OBJECTION: I am the parent/guardian of the child identified on the reverse side. Because of my bona fide religious beliefs and practices, I object to any immunization being given to my child.

Parent/Guardian's Signature

Date

Please list any health problems:

Illnesses: _____

Allergies: _____

Disabilities: _____

Medications: _____

NOTE: STAFF CANNOT ADMINISTER MEDICATION TO PARTICIPANTS

Authorization for Participation and Emergency Medical Treatment

If my child, _____, should become ill or injured at the OWCAS Cultural Arts Enrichment Before/After School Program, I understand that OWCAS will contact me immediately or contact the person(s) I have designated if I cannot be reached. Should the facility be unable to reach me and/or the contact person(s) designated, they are authorized to contact my child's physician and/or arrange for immediate medical treatment. The physician and/or medical facility are authorized to administer emergency medical treatment necessary to ensure the health and safety of my child. I grant permission for my child to participate in all activities in and around the City Neighbors Charter School and City Neighbors Hamilton as part of the Before/After School Program as included in the program description. Further, I agree to assume all risks and liabilities associated with my child's participation in said programs and to hold the OWCAS and City Neighbors Charter Schools harmless from all claims which may arise as a result of such participation. I will accept responsibility for payment of medical services rendered.

Parent/Guardian's Signature

Date

PARENT AGREEMENT

STUDENT CODE OF CONDUCT

In order to maintain a safe and peaceful camp environment we require parents and campers to read and comprehend the importance of abiding by the following code of conduct.

I will follow the program schedule and direction of program staff. I will not bring electronic items and cell phone will only be used for emergency. I will respect program staff, directors, and other students by not using foul language, name calling or fighting. I will follow all safety rules set forth by the program staff.

Student's Signature: _____ Date: _____

I agree to help my child abide by this code of conduct.

Parent Signature: _____ Date: _____

ACADEMIC RELEASE

I understand that participation in this program requires reporting to funding sources on the academic results of student participants. I recognize that specific individual academic grade or individual education plan (IEP) information will not be released outside One World Cultural Arts Society. I hereby authorize the release of my child's grade reports and notification of IEP status to One World Cultural Arts Society and will provide this information when possible.

Parent/Guardian's Signature

Date

PHOTO RELEASE

Participants in OWCAS educational programs may be photographed or video taped by the media or by OWCAS staff for promotional purposes. By signing this photo release you understand that there is a possibility that your child will be photographed or video taped while participating in a OWCAS program.

Parent/Guardian's Signature

Date

PAYMENT INFORMATION

Please check the participant enrollment schedule of choice.

Parent/Guardian will be required to make payment by the 15th of every month.

REGISTRATION FEE AND FIRST MONTH'S PAYMENT DUE AT TIME OF REGISTRATION.

Registration Fee	\$25
Before Care (7am – 8am)	\$75 per month
Monday – Friday	\$255 per month
Monday – Friday before 5pm	\$205 per month
Monday – Friday before 4pm	\$195 per month
3 Days a week	\$185 per month
2 Days a week	\$145 per month
1 Day a week	\$75 per month

Drop In Care (Must be Registered with Program)
(Credit Card or Automatic Withdrawal Required) \$20 per day

Healthy Snack is included in program cost.

Sibling Discount 15% for first child

Early Bird Discount \$10 off Payment
(Payments received by the 1st of the month)

Subtotal _____

Discount _____

Payment Total _____

Remaining Balance _____

(Please check payment below)

- Check # _____
 Money Order in the amount of \$ _____
 ACH (complete attached form)
 Visa / Master Card:

Credit Card #: _____ Expiration Date: _____ Code#: _____

Name on Card: _____

Signature: _____

Office Use Only: Registrar's Initials: _____

Processing Date: _____

ACH Authorization Form

All information on this form is required unless otherwise noted.

Business Authorized to Debit/Credit Account:

Authorized Business Name

Authorized Business Phone Number

Authorized Business Address

City

ST

Zip

Account Holder Information:

Account Holder Name

Account Holder DBA Name (If Business Account)

Account Holder Phone

Account Holder Address

City

ST

Zip

Account Holder's Bank Information:

Account Holder's Bank Name

Branch City

ST

Zip

How to find your Routing and Account Numbers on a check:



Business Checking

Personal Checking

Savings

Bank Routing Number (9 digits)

Bank Account Number

Transaction Information:

Goods Purchased/Services Rendered

One-time

Recurring

Rate

\$

Amount of Transaction

Effective Date

No. of Transactions

or Open Ended

Authorization:

In exchange for products and/or services listed above the undersigned hereby authorizes:

to electronically draft via the Automated Clearing House system the amounts indicated above from the account identified above. This authority will continue until withdrawn in writing by the undersigned account holder. The Undersigned hereby certifies that they are duly authorized to execute this form on behalf of the above listed account holder. I acknowledge that I am subject to a \$25 reject fee if items are returned for insufficient funds.

Signature of Account Holder

Name/Title of Account Holder

Date

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