



PARK ACADEMY

Ignite. Empower. Imagine.

2018 Summer School Application Grades 3-8

Submission of this application and a \$100.00 deposit for each session (applied to tuition) are required to attend our summer school program. The remaining balance of tuition will be due June 29, 2018. If your student is attending both morning and afternoon sessions, there will be a supervised lunch from 12:00pm - 12:30pm. Please bring your own food and beverages.

EXPLORING LITERACY, MATH & SOCIAL SKILLS THROUGH ENRICHMENT AND CREATIVITY

Morning Session | July 9 - August 3 (M-F) | 8:30am - 12:00pm | \$1,000.00

The Morning Summer Program at Park Academy will feature weekly themes of science, technology, writing and/or history. Through creative projects, students will do a deep dive into physics and medieval history. In addition, students will engage in collaborative group problem solving, experiential learning and physical fitness.

Afternoon Session | July 9 - August 3 (M-F) | 12:30pm - 4:00pm | \$1,000.00

The Afternoon Summer Program at Park Academy will focus on weekly themes of environmental stewardship, technology, writing and/or history. Through creative projects, students will do a deep dive into art, science and the Renaissance. In addition, students will engage in collaborative group problem solving, experiential learning and physical fitness.

PLEASE CHECK THE BOX FOR THE CLASSES YOU ARE REGISTERING FOR.

| Class | Cost | Deposit (\$100 per Class) | Remaining Balance (Cost - Deposit) |
|--|----------|------------------------------|--|
| <input type="checkbox"/> Morning Session | \$ 1,000 | | |
| <input type="checkbox"/> Afternoon Session | \$1,000 | | |
| TOTAL | | | |
| | | <i>(Due upon enrollment)</i> | <i>(Due 6/29/18)</i> |

Amount Enclosed: _____

Payment Method: Cash Check (made payable to Park Academy)

Credit Card Visa MasterCard American Express Discover
(Will incur a 2% processing fee)

Name on Card _____ Card Number _____

Exp. Date _____/_____/_____ CID _____ Billing Zip Code _____



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2018 Summer School Application

Applicant Information

| | | | |
|-----------------|---|--|---------------|
| Legal Last Name | Legal First Name | Preferred Name | Current Grade |
| Gender | Date of birth (<i>month/day/year</i>) | Place of birth (<i>city/state/country</i>) | SSN |
| Address | City | State | Zip |
| Phone | Parent/Guardian primary email address | | |

School Information

| | | | |
|----------------|-----------|-------------------|-----|
| Current School | Telephone | Grade(s) attended | |
| Address | City | State | Zip |

Parent/Guardian (A) Information

| | | | |
|--|---------------------------|------------|--------------------|
| Parent's/Guardian's Name | Relationship to applicant | | |
| Spouse/Partner, if not child's parent/guardian | | | |
| Address (if different from applicant) | | | |
| City, State and Zip | Home Phone | Email | |
| Cell Phone | Work Phone | Occupation | Employer/Firm Name |

Parent/Guardian (B) Information

Parent's/Guardian's Name Relationship to applicant

Spouse/Partner, if not child's parent/guardian

Address (if different from applicant) City, State and Zip Home Phone

Cell Phone Work Phone Email

Occupation Employer/Firm Name

Emergency Contacts & Health Information

Who should be notified in case of emergency other than parent/guardian

First Contact Name (other than parent) Relationship to applicant

Home Phone Work Phone Cell Phone

Second Contact Name (other than parent) Relationship to applicant

Home Phone Work Phone Cell Phone

Physicians Name Phone Hospital

Dentist Name Phone

Please indicate any medical conditions the school should be aware of:

| | | |
|-------------------------|------------------------|-------------------------|
| _____ Allergies/Specify | _____ Asthma | _____ Bleeding Disorder |
| _____ Bee Sting | _____ Migraines | _____ Diabetes |
| _____ Heart Condition | _____ Hearing Problems | _____ Seizures |
| _____ Vision Problems | | |

Other: _____

Please indicate any medications the student is currently taking:

In an emergency, if the Parent/Guardian, designated Physician/Dentist cannot be reached, I authorize Park Academy to transport and/or obtain medical services from any doctor for my child.

Parent/Guardian Signature

Date

STUDENT PROFILE

Please indicate your student's unique learning differences and needs: _____

Describe your child's interaction with peers: _____

Please share anything else that will help our staff serve and support your child: _____
