



**AFTERSCHOOL SPANISH PROGRAM
ENROLLMENT FORM
2019-2020**

Office Use

Trial Class-Date: _____
Enrollment Fee _____
Tuition _____
Attendance Lists _____
Binder _____
Book _____
E-mail _____
QB _____

3368 Bonita Rd.
Chula Vista, Ca 91910
Ph/fax: 619-422-1777

Email: info@bonitalearningacademy.com

Website: www.bonitalearningacademy.com

IMPORTANT NOTICE: YOUR CHILD IS NOT OFFICIALLY ENROLLED UNTIL THE POLICY AGREEMENT PACKET HAS BEEN COMPLETED AND THE ENROLLMENT FEE AND TUITION HAVE BEEN PAID.

CHILD'S NAME: _____ PREFERRED NAME: _____
BIRTHDATE: _____ AGE: _____ (years/months) SEX: F M PLACE OF BIRTH _____
LANGUAGE SPOKEN AT HOME: _____ CULTURAL BACKGROUND: _____
ADDRESS: _____ CITY/STATE/ZIP: _____
NAME OF CURRENT OR PREVIOUS SCHOOL: _____

CIRCLE ONE: MOTHER/FATHER/GUARDIAN
NAME: _____

OCCUPATION: _____

HOME ADDRESS: _____ HOME PHONE: _____

COMPANY NAME: _____ WORK PHONE: _____

E-MAIL: _____ CELL PHONE: _____

CIRCLE ONE: MOTHER/FATHER/GUARDIAN
NAME: _____

OCCUPATION: _____

HOME ADDRESS: _____ HOME PHONE: _____

COMPANY NAME: _____ WORK PHONE: _____

E-MAIL: _____ CELL PHONE: _____

CHILD LIVES WITH: _____

PLEASE NOTE ANY CUSTODY RESTRICTIONS: _____

PHYSICIAN'S NAME: _____ PHONE #: _____

DOES YOUR CHILD HAVE ANY SPECIAL NEEDS, HEALTH ISSUES, ALLERGIES OR SPECIAL DIET THAT WE SHOULD BE AWARE OF? YES _____ NO _____

IF YES, PLEASE EXPLAIN: _____

SIBLINGS: _____ DOB: _____

SIBLINGS: _____ DOB: _____

SIBLINGS: _____ DOB: _____

SIBLINGS: _____ DOB: _____

PERSONS ALLOWED TO PICK UP CHILD FROM SCHOOL:

❖	NAME (First and Last)	RELATIONSHIP		
HOME	WORK	CELL	OTHER	
❖	NAME (First and Last)	RELATIONSHIP		
HOME	WORK	CELL	OTHER	
❖	NAME (First and Last)	RELATIONSHIP		
HOME	WORK	CELL	OTHER	
❖	NAME (First and Last)	RELATIONSHIP		
HOME	WORK	CELL	OTHER	

****PLEASE NOTE THAT IF ANOTHER PERSON NOT INCLUDED IN THIS LIST WILL BE PICKING UP YOUR CHILD, YOU ARE REQUIRED TO SUBMIT IT IN WRITING TO THE OFFICE AHEAD OF TIME. WE WILL SOLICIT CURRENT STATE ISSUED PHOTO IDENTIFICATION PRIOR TO THE RELEASE OF ANY CHILD.**

**CONSENT FOR EMERGENCY MEDICAL TREATMENT-
Child Care Centers or Family Child Care Homes**

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO BONITA LEARNING ACADEMY TO PROVIDE ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A LICENSED PHYSICIAN (M.D.) OR DENTIST (D.D.S.) FOR MY CHILD . THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB, OR WELL BEING OF THE CHILD NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

DATE	PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE
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HOME ADDRESS

HOME PHONE ()	WORK PHONE ()
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BONITA LEARNING ACADEMY
AFTER SCHOOL SPANISH PROGRAM
POLICY AGREEMENT
2019-2020

We (parents /guardians) of _____ have read the Policy Agreement
and accept and agree to the conditions as stated.

Signature of Parent or Guardian

DATE:

I hereby authorize my child to use Antibacterial Hand sanitizer (alcohol base) provided by B.L.A.

Yes___ No___

PROGRAM: (circle one) **1** **2** **3**

1. SPANISH FOR SPANISH SPEAKERS.

2. SPANISH AS A SECOND LANGUAGE.

3. AFTERSCHOOL PRE-SCHOOL/KINDERGARTEN.

Enrollment Fee (Registration/books & materials): \$ 110.00

Tuition fee for this program: \$ 130.00

2nd sibling: \$ 117.00 (10% sibling discount)

3rd sibling: \$ 65.00 (50% sibling discount)

Sibling discount: YES NO _____ %

Starting date: Thursday, September 5, 2019

Hours: 4:00 pm – 6:00 pm

Student(s)' Name: _____



DIRECT PAYMENT AUTHORIZATION

One Account

I (we) hereby authorize Bonita Learning Academy, hereinafter called "Bonita Learning Academy aka Castaños & Flores, Inc.", to initiate debit entries and, if necessary, debit correction and adjustment entries to my(our) account at the financial institution listed below for the **2019-20 school year.**

Financial Institution Name: _____

Branch: _____

Address: _____

City/State: _____

Zip: _____

Routing & Transit Number: _____

Account Number: _____

Account Type:

Checking/Draft

Savings/Share

You may choose a payment day of the 1st, 5th or 10th for your Direct ACH monthly payment. This authority is to remain in full force and effect Sept , 2019 to May , 2020. This account will be used to pay for Tuition & Enrollment Fees for the Afterschool Spanish Program.

Parent(s) Signatures _____

Printed Name(s) _____

Date: _____

(Please attach a voided check or financial institution account verification letter to this form.)



Monthly Payment

Date: _____

_____ Monthly Tuition

_____ Prepaid Extended Care

_____ Total

.....
.....

_____ Total Monthly Charge