

# **AFTER-SCHOOL ACTIVITIES PROGRAM**

***OUR LADY OF VICTORY CATHOLIC SCHOOL  
STATE COLLEGE, PA 16801  
814-238-1592***

## **PARENT CONTRACT 2008-2009**

I understand that the ASAP program is offered from immediately after school until 5:30 P.M. It will begin on the first day of the school year. There will be no ASAP on the last day of school or on any in-service days. If school closes early because of snow, etc. there will be no ASAP, and it will be my responsibility to see that my child is picked up as soon as possible.

I will receive a bill monthly, and payment is due by the last school day of the month. All checks should be made payable to: OLVCS-ASAP Program. There is a payment box in the office.

**My child must be picked up by 5:30 P.M. IF I ARRIVE AFTER 5:30 P.M., I WILL PAY A LATE CHARGE OF \$30.00.**

I will send an after-school snack with my child, or my child can purchase one for \$.65 per day. I understand that this cost will be included on my monthly bill.

**FEES:** \$4.00 per hour or part of an hour for students with contracts

\$15.00 per day for Emergency Use for students without contracts

PARENT'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

# AFTER-SCHOOL ACTIVITIES PROGRAM EMERGENCY INFORMATION

CHILD'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

GRADE & TEACHER'S NAME: \_\_\_\_\_

FATHER'S NAME: \_\_\_\_\_

Phone Numbers (for emergency): \_\_\_\_\_

MOTHER'S NAME: \_\_\_\_\_

Phones Numbers (for emergency): \_\_\_\_\_

\*\*\*\*\* AT NO TIME WILL YOUR CHILD BE RELEASED \*\*\*\*\*  
TO ANYONE OTHER THAN THE PERSONS LISTED  
ON THIS FORM WITHOUT YOUR CONSENT

My child may be picked up by:

1.

2.

3.

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_