

Winter EDUCATION PROGRAMS

REGISTRATION FORM

2535 South King St., Suite 304

Honolulu Hawai'i 96826

Telephone: 955-6100

Student Information:

Student Name: _____ Gender: _____ Referred By: _____

Address: _____ City: _____ Zip Code: _____

D.O.B: _____ Age: __ Grade as of 8/23: __ School: _____ Native Hawaiian? Yes No

1. Parent Name: _____

Business Ph#: _____ Cell: _____ E-mail: _____

2. Parent Name: _____

Business Ph#: _____ Cell: _____ E-mail: _____

Emergency Contact: _____ Ph #: _____ Relationship: _____

Persons Authorized to Pick Up Student: _____

Allergies/Sensitivities/Medical Conditions: _____

Does your child have an IEP/504? _____ (If yes, please attach a copy of the most recent IEP/504)

Other interventions/services previously/currently receiving: _____

Medical Waiver/Release and Consent for Emergency Treatment

I, the parent/guardian of (child's name) _____, hereby release EPIC Foundation and its employees and volunteers, and waive all responsibility on their part for any liability with respect to any and all travel, and activities participation for my child named above and/or any loss of property that may occur at such a time. This waiver and release extends to any and all activities, travel to and from any and all activities, and participation in any and all activities, and shall release EPIC Foundation and its employees and volunteers from any liability except for gross or willful negligence with respect to an injury to my child. It is understood that activities, etc. can be dangerous and I am responsible for evaluating my child's ability to participate in any and all activities and am responsible for any and all insurance to cover my child's participation in any and all activities. I certify that my child is insured and able to participate in any and all activities as part of the EPIC Journeys program administered by EPIC Foundation.

If, in the judgment of any representative of EPIC Foundation, my child should need immediate care and treatment as a result of any injury or illness, I do hereby request, authorize and consent to such care as may be given my child by a physician, trainer, nurse, EPIC Foundation employee or volunteer, and I do hereby agree to indemnify and release EPIC Foundation and its employees and volunteers from any and all claims by any person whomever on account of such care and treatment of my child. Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examination and immunizations for my child. In the event of serious illness, significant accidental injury, or the need for professional medical attention, I understand that an attempt will be made by a representative of EPIC Foundation to contact me and/or the person I list as an Emergency Contact on this form in the most expeditious way possible. If I or the person I list as an Emergency Contact on this form are unable to be contacted, the treatment necessary for the best interest of my child, the above-named participant, may be given.

In the event that my child requires medication I will provide the medication and any and all information required to the administering of said medication and do authorize EPIC Foundation its employees or volunteers to administer said medication to my child as explained on the instructions I am responsible to provide.

Hospital Preference _____

Doctor _____ Phone _____

Insurance Company _____ Policy # _____

Allergies/Sensitivities _____

Medication (type/name and dosage information such as amount and how often) _____

Medical History (recent injuries, hospitalization, etc.) _____

Consent to Photograph and Media Release

Photographs and video are taken of the students and staff for many of the class and group activities. I hereby give EPIC Foundation permission to use such pictures/images in public displays and media releases (e.g. web page, bulletin boards, newsletters, brochures). Student names will never be used. Parents may ask for copies of the photographic images at any time.

Financial Agreement

I agree to pay all tuition in full prior to the start of each class. Should an account become outstanding it will be referred to an attorney for collection, at which time I will accept responsibility for all reasonable attorney fees and collection expenses.

___ I would like to enroll my child in EPIC Winter Journeys 2023. Enclosed is the tuition of \$360 paid in full. It is understood that no credits will be allocated for illness, personal vacation, or other interruptions in attendance.

___ I would like to enroll my child in EPIC Winter Journeys 2023 Aftercare Program. Enclosed is the tuition of \$160. It is understood that no credits will be allocated for illness, personal vacation, or other interruptions in attendance.

Enrollment is by order received. Due to the small class size we will notify you should your child be waitlisted.

I have read, fully understand, and agree to all conditions set forth in the Medical Waiver/Release and Consent for Emergency Treatment, Consent to Photograph and Media Release, and Financial Agreement.

Parent Signature _____ Date _____

Print Parent Name _____

Make checks payable to: EPIC Foundation

Mail to: EPIC Journeys
2535 South King Street, Room 304
Honolulu, Hawai'i 96826

For Office Use Only

Tuition Information: _____

- _____ Copy to WP
- _____ Copy to AH
- _____ Copy to web-folder
- _____ File to registration folder

- _____ Create student file
- _____ Enrollment: Renaissance Math
- _____ Enrollment: _____
- _____ Enrollment: _____