



kuei luck enrichment center

快樂教育中心

2012 SPRING BREAK INTENSIVE ELA & MATH TEST PREP COURSE

ACCT (OFFICE USE) _____

STUDENT INFORMATION:

DATE: _____

STUDENT ID (PLEASE FILL IF KNOWN, OTHERWISE LEAVE BLANK): _____

FIRST NAME: _____ LAST NAME: _____

AGE: _____ BIRTH DATE: ____/____/____ (MM/DD/YY)

SCHOOL: _____ GRADE: _____

PARENT/GUARDIAN: _____

ADDRESS: _____

CITY: _____ STATE: _____ POSTAL CODE: _____

TELEPHONE NUMBER: (H) (____) ____-____ (W) (____) ____-____
 (C) (____) ____-____

EMAIL ADDRESS: _____

R

EMERGENCY CONTACT:

EMERGENCY CONTACT (FIRST NAME LAST NAME): _____

PHONE NUMBER: (H) (____) ____-____ (W) (____) ____-____
 (C) (____) ____-____

MEDICAL INFORMATION:

PLEASE LIST ANY KNOWN ALLERGIES:

AGREEMENT (NON-NEGOTIABLE):

I HEREBY GRANT PERMISSION FOR MY CHILD TO ATTEND KUEI LUCK ENRICHMENT CENTER AND PART TAKE THEIR PROGRAM. I GRANT KUEI LUCK ENRICHMENT CENTER THE RIGHT TO TAKE AND USE PHOTOS AND VIDEOS OF MY CHILD FOR PROMOTIONAL PURPOSES. I, THE PARENT OR GUARDIAN OF THE SAID STUDENT, HEREBY AGREES TO REIMBURSE KUEI LUCK FOR ANY PROPERTY DAMAGE CAUSED BY THE STUDENT. I UNDERSTAND THAT THERE WILL BE NO REFUNDS AFTER THE PROGRAM STARTS OR FOR A STUDENT WHO HAS BEEN EXPELLED DUE TO DISCIPLINARY ACTIONS. THE DIRECTOR RESERVES THE RIGHT TO DISMISS A STUDENT WHO, AFTER CAREFUL CONSIDERATION AND EXAMINATION, IS DEEMED A HAZARD TO THE SAFETY OR RIGHTS OF OTHERS OR WHO APPEARS TO HAVE REJECTED THE REASONABLE EXPECTATIONS OF THE PROGRAM. KUEI LUCK ENRICHMENT PROGRAMS DO NOT GUARANTEE RESULTS ON ANY EXAMS, REPORT CARD GRADES OR ADMISSION TO ANY SCHOOLS.

I AGREE TO PAY A \$25 ADMINISTRATION FEE FOR ALL BOUNCED CHECKS. I UNDERSTAND AND AGREE THAT A LATE FEE OF \$3.00 PER 5 MINUTES WILL BE ASSESSED.

I AUTHORIZE KUEI LUCK ENRICHMENT CENTER AND ALL ITS' STAFF TO ACT ACCORDINGLY TO THEIR BEST JUDGMENT IN ANY EMERGENCY REQUIRING MEDICAL ATTENTION. I HEREBY WAIVE AND RELEASE KUEI LUCK ENRICHMENT CENTER AND/OR ITS DESIGNEES FROM ANY AND ALL LIABILITY AND COSTS ASSOCIATED WITH THE CAMP. I FURTHER UNDERSTAND THAT I OR MY MEDICAL INSURANCE CARRIER WILL BE RESPONSIBLE FOR ANY EXPENSES ARISING FROM SAID EMERGENCY OR TREATMENT.

I HEREBY CERTIFY THAT THE INFORMATION ABOVE IS ACCURATE.
 I HEREBY CERTIFY THAT I HAVE READ AND ACCEPTED ALL THE ABOVE CONDITIONS.

 PARENT / GUARDIAN SIGNATURE

 DATE



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ACCOUNTING (FOR OFFICE USE ONLY)

TUITION	\$450.00	+ _____
DISCOUNT		- _____
TOTAL		= _____

CHECK	CASH
BANK: _____	
CHECK NO: _____	
RECEIPT NO: _____	
REGISTERED BY: _____	
ENTERED BY: _____	