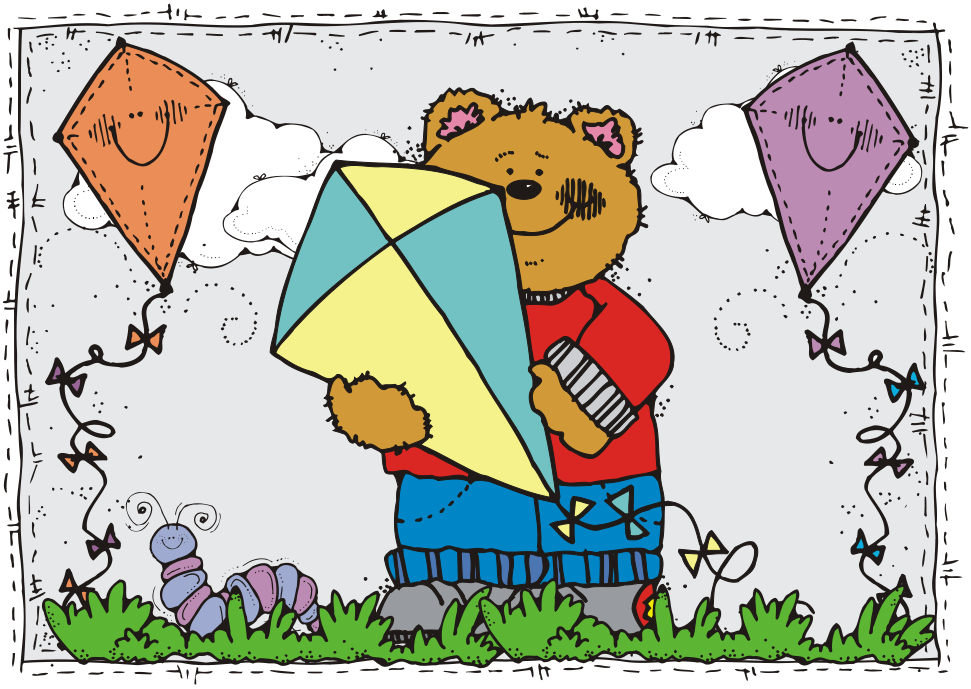
APPLICATION

FOR



Summer Program 2024

11330 E. 166th Street, Cerritos, CA 90703
Tel: (562) 865-2424 Fax: (562) 865-8146
E-mail: learning@fecc.us

Submit completed application to the FECC Children Academy office with the $40.00 nonrefundable registration fee.

FECC SUMMER PROGRAM ENROLLMENT FORM

Present date ____/____/_____

Child's Full Name _____
Last First Middle

Date of Birth _____/_____/_____ Male _____ Female ____
mo day year

Going to 1st grade_____ 2nd Grade _____ 3rd Grade _____ 4th Grade _____ 5th Grade _____ 6th Grade _____ 7th Grade _____
(Check class appropriates for child)

PARENTS' INFORMATION

PARENT/GUARDIAN #1

Mr/Mrs/Ms _____ Home Phone ( ) _____ – _____

Home Address _____ Mobile Phone ( ) _____ – _____

City/Zip_____

Lives with student? Yes No

Relation to Student _____ Billing party? Yes No

Employer/Occupation _____Work Phone ( ) _____ – _____

E-mail: _____

PARENT/GUARDIAN #2

Mr/Mrs/Ms _____ Home Phone ( ) _____ – _____

Home Address _____ Mobile Phone ( ) _____ – _____

City/Zip_____

Lives with student? Yes No

Relation to Student _____ Billing party? Yes No

Employer/Occupation _____Work Phone ( ) _____ – _____

E-mail: _____

EMERGENCY CONTACT

Other than parents, ***CHILD WILL BE RELEASED ONLY TO PERSONS INDICATED BELOW*** *(Must include at least* ***TWO*** *local persons to call for illness, accident, late pick-up, or other emergency reasons). Please list them in the order of preference for us to contact.*

1. Mr./Mrs./Ms _____ Home Phone ( ) _____ – _____

   Home Address _____ Mobile Phone ( ) _____ – _____

   City/Zip _____ Work Phone ( ) _____ – _____

   Relation to Student _____

2. Mr./Mrs./Ms _____ Home Phone ( ) _____ – _____

   Home Address _____ Mobile Phone ( ) _____ – _____

   City/Zip _____ Work Phone ( ) _____ – _____

   Relation to Student _____

3. Mr./Mrs./Ms _____ Home Phone ( ) _____ – _____

   Home Address _____ Mobile Phone ( ) _____ – _____

   City/Zip _____ Work Phone ( ) _____ – _____

   Relation to Student _____

MEDICAL INFORMATION

Name of child's physician or clinic _____

Physician address and phone_____

_____

Name of medical insurance and policy no. _____

_____

Medical attention _____

Allergies**:** _____

FECC Summer Program

We, the parents of _____, will like to enroll my child to the summer program offered by FECC. I understand that I am responsible to read the Summer Program Handbook, understand and abide by its contents, and cooperate with the policy, refund policy, and the purpose of FECC Summer Program. We further understand that the Bible and religious teaching are a part of every aspect of FECC Summer Program.

Father's signature _____

or

Mother's signature _____

Consent to medical care and treatment of minor child

I, _____, hereby give permission that my child _____, may be given emergency treatment, to include first aid and CPR by a qualified staff member of FECC Summer Program. I further authorize and consent to dental, medical, surgical, and hospital care, treatment, and procedures to be performed for my child by a licensed dentist, physician, or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health if I cannot be contacted. In such case, I waive my right of informed consent to such treatment.

I also give permission for my child to be transported by ambulance or other transportation to an emergency center for treatment. I further authorize FECC to take my child to a hospital, and agree that I will pay all dental, medical and hospital bills, and FECC shall not be responsible for them.

Signature of Parent/Guardian _____ Date _____

2024 FECC Summer Program Field Trip Permission Slip Form

Class: FECC Summer Program Teacher: FECC Faculty

Destination: All FECC Summer Program field trips

Dates: 06/3/2024 – 08/2/2024 Departure & Returning Time: Please check the weekly field trip information given out on Monday

Transportation: FECC Church Buses, School Buses, and/or Authorized Faculty Vehicles

Please fill out this form as completely and clearly as possible.

Child's Name:_____ Age:_____

Address:_____

_____

Parent 1:_____

Phone: _____ Alt. Phone:_____

Parent 2: _____

Phone: _____Alt. Phone:_____

Authorized Contact Person: _____

Phone: _____ Alt. Phone: _____

Insurance Carrier: _____

Policy and ID Number:_____

Allergies, and/or medical condition: _____

_____

By signing this form, you authorize FECC to call an emergency ambulance in case of an accident or acute illness and to arrange for necessary emergency medical and surgical care in case you are not immediately available. Any qualified physician called by FECC may treat and do whatever necessary for the health and well-being of your child. You agree to accept responsibility for the cost of any medical services. A conscientious effort will be made to notify you before such action are taken.

Parent Signature: _____ Date: _____