



Focused Reality \* PO Box 240995 Honolulu, Hi 96824 \* 779-3878

### Registration for School Year 2009-2010

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Gender: M / F  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_  
City, State, Zip Code: \_\_\_\_\_ Current School: \_\_\_\_ Current Grade: \_\_\_\_

### Emergency Contact – Main Contacts

Guardian/Mother's Name: \_\_\_\_\_ Primary Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Guardian/Father's Name: \_\_\_\_\_ Primary Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

### Authorized Pick-Up Information

I authorize the following people to pick-up my child. I will inform the business office in writing to make any changes. Please note staff will only allow authorized persons to pick up your child. Only Main contacts will be allowed to approve/disapprove other persons. Additional authorized persons DO NOT have authority to do so.

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Cell #: \_\_\_\_\_

### Medical Information and Release Waivers

Doctor's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Insurance: \_\_\_\_\_ Choice of Hospital/Clinic: \_\_\_\_\_

If in the judgment of Focused Reality staff, my children requires medical care, I authorize and instruct Focused Reality to inform me or the authorized persons listed above. Focused Reality may take my child/teen in for medical treatment to the physician, hospital, or clinic designated by myself or authorized person. If the authorized person, the physician or I can't be promptly reached. I authorize Focused Reality to call for emergency transportation or to take my children to the nearest hospital or clinic for treatment.

Please list any of your child's medical conditions (allergies, medication, limitations, requirements, etc)

\_\_\_\_\_  
\_\_\_\_\_

I also authorize Focused Reality to use the name and any video/photographs/audio taken of my child and or myself at anytime or in any manner in connection with its advertising, publicity, and public relations programs. Focused Reality only use the video/photographs/audio. I will make no further claims.

**In signing below, I acknowledge I have read and understand the above information.  
Contact the Executive Director or Assistant to clarify any questions, comments or concerns.**

Parent/Guardian's Name Printed: \_\_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Program Schedule

Single class sign-ups and drop-ins are welcome!

<b>Session 2009</b> <b>7 days</b>	<b>8am-1:30pm</b> <b>5 ½ hours</b>	Package or Single Classes Available After Program Care Available		
Oct 23	Oct 30	Nov 6	Nov 20	Dec 4
Dec 11	Dec 18			
<b>Session 2010</b> <b>10 days</b>	<b>8am-1:30pm</b> <b>5 ½ hours</b>	Early Bird Package Price Available		
Jan 15	Jan 29	Feb 5	Feb 12	Mar 5
Mar 12	Apr 23	Apr 30	May 7	May 14

Includes a \$25 non-refundable application fee

## Two and Three Payment Plans Available! Satisfaction Guaranteed!

### Online-Secure Payments @ [www.IMAGconnects.org](http://www.IMAGconnects.org)

### Parent/Guardian Consents and Responsibilities—Initial , Fill and Sign-Mahalo!

1. \_\_\_ This certifies that (child's name) \_\_\_\_\_ has had a health examination within the current year and that his/her general health permits participation in all activities.
2. \_\_\_ The use of "I" includes myself, personal representatives, executors, heirs or assigns.
3. \_\_\_ Information given will be kept in strict confidence.
4. \_\_\_ Your child's safety is of utmost importance. I give my consent to the program staff to take appropriate action to maintain the safety of my child. The staff will first try to contact me. If unable to reach me, contact will be to the person/agencies listed on my registration form.
5. I understand and agree that
  - \_\_\_ I will be responsible for the safety of my child before and after the program's scheduled hours. I **will not** leave my child (ren) unattended before or after the program start/end times. I will make the appropriate arrangements to ensure this doesn't happen.
  - \_\_\_ I will notify the program office of any changes regarding the information on this registration form (ie address, phone #s, physician, medical conditions, etc)
  - \_\_\_ I will notify the program office prior to the start of the day if my child will be absent.
  - \_\_\_ No staff can or will dispense any type of medication to my child.

Parent/Guardian's Name Printed: \_\_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Notes: \_\_\_\_\_