



Somerset Academy – Sibling Care

A Broward County Public Charter School

2009 – 2010

Child's Name: _____ **Date of Birth:** _____ **Age:** _____

Address: _____ **City:** _____ **Zip:** _____

Sex: M or F (please circle one)

Race: White Black Hispanic Asian/Pacific Islander American Indian/Alaskan Native Other
(please circle one – information is for demographic use only)

Grade: _____ **Teacher:** _____ **No. of Siblings in Program:** _____

Mother's Name: _____ **Home Phone:** _____

Place of Employment: _____ **Work Phone:** _____

Cell Phone: _____

Father's Name: _____ **Home Phone:** _____

Place of Employment: _____ **Work Phone:** _____

Cell Phone: _____

Emergency Contact Name: _____ **Emergency Contact Phone:** _____

Doctor's Name: _____ **Doctor's Phone:** _____ **Doctor's Address:** _____

Insurance Company: _____ **Insurance Policy #:** _____

Medical Needs/Allergies/Other Special Needs: _____

RELEASE In case of a medical emergency, I hereby give permission to the physician selected by Somerset Academy to order x-rays, routine tests, and treatment for the health of my child. In the event that I cannot be reached in an emergency, I give my permission to the physician selected by Somerset Academy to hospitalize, secure treatment for, and to order injection and/or surgery for my child as named above. I understand that my personal insurance bears responsibility in case of accident. Furthermore, I the undersigned, accept all risk incidental to Somerset Academy activities and do hereby release Somerset Academy, its officers, and its representatives from all liabilities deriving from pursuits of said activities by my child. It is further agreed that Somerset Academy assumes no responsibility for loss of participants personal property. I give my permission for my child to participate in activities, walk to Rose Price Park, and field trips. I also give my permission to Somerset Academy to use any pictures taken of my child for future promotional purposes. I agree to pay in full all fees prior to participation in Sibling Care pursuant to the following schedule in effect through June 9, 2010. In addition, I agree to pay upon representation of notice any late pick-up or NSF/ISF Bank charges pursuant to the Parent/Student Handbook. I further agree that registration in the student medical accident insurance is necessary in order to participate in the sibling care program.

Authorized Signature _____

Date _____





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Sibling Care is provided in the morning to brothers and sisters of students in our Middle or High school for a registration fee of \$20 per student for the entire school year. We will no longer offer afternoon sibling care but special arrangements can be made with our LEAP program.

All non sibling students must register for, and pay for, Morning Care.

SIBLING CARE REGISTRATION FORM – MORNING CARE

Child's Name: _____

Grade: PK K 1 2 3 4 5

Teacher's Name: _____

Sibling Name: _____

Sibling Grade: 6 7 8 9 10 11 12

Sibling Homeroom: _____

I understand that due to the changing of the Middle and High school hours there is no more afternoon sibling care. All elementary students must be picked up at dismissal (2:15pm) or registered in the LEAP program.

I understand that sibling care begins at 7:15am, and if I drop my child off before 7:15am I will be subject to morning care fees.

Signing below, I agree to uphold all of the policies and procedures listed above.

X _____
Parent signature date

