



CHARLES JUNE

Karate Institute

650 E Fire Tower Rd (252) 7KARATE
 Winterville, NC 28590 (252) 752-7283

2018/19 After-School Student Enrollment Information

_____	____/____/____	_____	_____
Student 1	Date of Birth	Grade	School
_____	____/____/____	_____	_____
Student 2	Date of Birth	Grade	School
_____	____/____/____	_____	_____
Student 3	Date of Birth	Grade	School

- 2018/19 School Year Pricing**
- After School & Summer 2018..... \$95/wk or \$380/mo
 - After School Full-Time..... \$80/wk or \$320/mo
 - After School Part-Time..... \$65/wk or \$260/mo
- Siblings (Part-Time) -- Subtract \$5/wk or \$20/mo
 Siblings (Full-Time) -- Subtract \$10/wk or \$40/mo
- Automated Billing -- Subtract \$5/wk or \$20/mo

Weekly/Monthly Rate (Office Use Only)	
Student 1	\$
Student 2 (sibling)	\$
Student 3 (sibling)	\$
Discounts	-
Total Wk/Mo Rate	\$

Parent/Guardian Information

 Parent/Guardian Name #1 Street Address City State Zip Code

(____)____ - ____ (H/M/W) (____)____ - ____ (H/M/W) _____
 Preferred Phone Secondary Phone Preferred Email

 Parent/Guardian Name #2 Street Address City State Zip Code

(____)____ - ____ (H/M/W) (____)____ - ____ (H/M/W) _____
 Preferred Phone Secondary Phone Preferred Email

 Other Emergency Contact Person and phone numbers (____)____ - ____ (____)____ - ____

Approved Pick-Up List

If anyone other than the parent/guardian listed above will be picking up your child, please list the full name of each individual with full permission to pick up your child.

Name: _____ Name: _____

Name: _____ Name: _____

Those individuals named above will need a picture id in order to pick up your child.

Additional Information About Your Child

-Food or Drug Allergies: _____

-Please list any medications your child is taking. This information will only be used in case of an emergency, to better assist health care providers. _____

If your child has medication to be administered by our staff, it must be in the pharmacy-labeled container with the instructions clearly printed. You must sign a permission slip to allow our staff to administer this medication.

-List any special needs or dietary restrictions: _____

-Please provide any information you feel would be helpful in teaching and working with your child (how your child best learns, communication techniques, how to best work with your child in dealing with behaviors, what you feel encourages your child the most, what situations make your child uncomfortable or activities we should avoid, strengths etc.) _____

Permission for Emergency Care

I hereby give my consent to Charles June Karate to call 911 in the event of an emergency and I hereby give my consent to any emergency facility or physician to administer necessary treatment to my child in the event of an emergency. I give my consent to transport by ambulance as/if the situation warrants.

Signature

Date

Terms and Conditions

_____**Payments:** We accept Cash, Check, or Visa/MC/Discover. Payments can be made through Automated Billing or paid at the school. Monthly payments are due on the first of the month. Weekly payments are due on Monday of each week. **The first week's payment should be included when registration is submitted.**

_____**Waiver:** I am aware that students will engage in physical exercise and use of training equipment. Training and instruction can cause injuries and I assume all risk of injuries which may result. I hereby waive and release any claim or right to sue Charles June Karate, its instructors or staff for student injuries. I also understand and agree that Charles June Karate is not responsible or liable for any loss, damage or theft of any property belonging to me or student even if the loss, damage or theft occurs on or around the Charles June Karate property.

_____**Pickup:** Pickup is by 6pm, unless the child has a 6pm class. Then, pickup is at the end of the class. **A late pickup fee will be assessed in the event that a child is picked up late without prior arrangements being made: \$5 for each 5 minutes after 6pm or the end of the child's class.**

_____**Photo Release:** Photographs may be taken of students to be used in publications including the Charles June Karate website. I hereby consent and release Charles June Karate from any expectation of confidentiality for the student(s) identified on page 1. If the student(s) identified is a minor, I further attest that I am the student's parent or legal guardian.

_____**Additional Terms:** You are registering your child(ren) for the 2018-19 school year for After School or After School plus Summer Camp as indicated in the Enrollment Information section. You are responsible for payment for each week/month regardless of your child's attendance. Refunds/credits/discounts are not available due to changing to a lower cost plan during the year. Withdrawing your child requires a four-week written notice. You are responsible for payments through the end of this four-week period regardless of your child's attendance. Charles June Karate will provide after school/summer camp services including Martial Arts classes during normal after school/summer camp operating hours. Additional Martial Arts classes may be available at other times and all class schedules are subject to change without notice.

Print Name

Signature

Date



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Credit/Debit Card *Monthly Recurring Payment Authorization Form*

To enjoy the convenience of automatic billing, simply complete and sign this form to get started!

Here's How Recurring Payments Work:

You authorize regularly scheduled charges to your Visa, MasterCard or Discover card. Your card will be charged each month for the amount authorized – your regular monthly fee(s). The charge will appear on your monthly credit card statement.

Please complete the information below:

I _____ authorize Charles June Karate and Landry Gray After
(print full name)

School to charge my credit/debit card indicated below on the _____ of each month for payment of my
monthly Karate and/or After School fees. (Choose 1st - 5th)

The monthly charge will be in the amount of \$ _____

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: Visa MasterCard Discover

Cardholder Name _____

Account Number _____

CVS (3digit code) _____

Expiration Date _____

SIGNATURE _____

DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.