



462 SW Port Saint Lucie BLVD, Port Saint Lucie FL 34953

Email: Info@KidSpaceRocks.com WWW.KidSpaceRocks.com

Phone: 772-340-2140 Fax: 772-336-7022

Kid Space Afterschool Registration

Student's Name _____	Date of Birth _____
Entering Grade _____	School Attending _____
T Shirt Size _____	
Street Address _____	
City _____	State _____ Zip Code _____
Best Daytime/Emergency Contact & Number _____	

Parents/Guardians Contact Information

Names _____	
Address (if different from above) _____	
City _____	State _____ Zip Code _____
Home Phone _____	Mom's Cell _____
Dad's Cell _____	Mom's Work _____
Dad's Work _____	Alternate # _____

Tell us about your child: Every child is unique, please use this space to fill us in on any concerns you may have, and also make us aware of any behavioral or developmental issues affecting your child in order to better assist us in caring for him/her.

Allergies/Medical Conditions:

Please list any and all allergies or medical conditions

Dietary Restrictions:

Emergency Contact Information

Name: _____	Phone: _____
Relationship to Child _____	
Name: _____	Phone: _____
Relationship to Child _____	
Name: _____	Phone: _____
Relationship to Child _____	

Release For Pick Up

Please name 3 people in addition to you or your spouse who may sign out your child from our center without prior written permission. These individuals will be allowed to remove your child from our care without contact from you, after showing a valid driver's license. (Id will be required)

_____ Name	_____ Relationship to Child
_____ Name	_____ Relationship to Child
_____ Name	_____ Relationship to Child

Please notify the Director in writing of any persons who are to have no contact with your child.
Please include a copy of any **No Contact Order** per any court decision.
This includes custody disputes.

By signing below, you state that that you have read and agree to the rules and conditions outlined in
the Kid Space Policies and Procedures.

Media Release:

I understand that both still and video images may be taken of my child and may be used in advertising material or on Kid Space/ Sochin Martial arts websites, as well as posted to our Facebook page.

Parent/Guardian Signature

Date

Kid Space Transportation /Medical Release Form

As the parent/guardian of _____, I hear by grant consent for him/her to participate in Kid Space approved field trips while enrolled in Kid Space from August 1st, 2023 - August 30, 2024. I have been advised in writing or by verbal notification of all trips available to my child over the course of the school year & summer, including destinations, dates and travel arrangements.

It is my understanding that Kid Space will advise me by written or verbal notification of any changes to the posted schedule in sufficient time to enable me to communicate any withdrawal of consent for the specific trip or activity. Trip changes will be posted in the front lobby.

I understand that Kid Space LLC and it's subsidiaries will be held harmless from any damages or claims that might arise from injuries out of any act or omission on the part of Kid Space as a result of such any trip or activity or while on property at Kid Space.

I understand that travel arrangements for my child include walking to locations within reasonable distances, such as other businesses in our plaza. When walking students will remain on sidewalks and off main roads. When driven my child will be in a Kid Space approved vehicle and driven by an approved driver. Although Kid Space vans will be the primary transportation, approved chaperoning parents will be allowed to transport my child as well with prior verbal notification.

Authorization for Treatment

As the parent/guardian of the above named student, I hear by give authorization to the staff of Kid Space LLC to transport my child to the nearest emergency room if for any reason they require minor medical treatment. I understand that emergency medical personal may be called to transport at the discretion of the director. I further authorize the hospital it's medical staff to administer treatment as deemed necessary for the well-being of said student.

I understand that the staff will make every attempt to notify me in all medical emergencies, and I will be contacted if possible for my permission if hospitalization or treatment of a serious nature is required.

I have read and understand the above and freely give my consent and permission of all things contained herein.

Parent/Guardian Signature

Date

Child's Full Name _____

Child's Date of Birth _____ Child's Weight _____

Parent/Guardian Contact (best daytime number) _____

Kid~Space Afterschool Enrollment Contract
Fall/ Winter 2023-2024

I understand that by registering my child (children) for

Aftercare _____ or Before & Aftercare or _____ Before care only _____

I am entering into a binding contract with Kid Space LLC. By choosing the weeks my child (children) will attend on page 1 of this contract I am agreeing to pay for these weeks, regardless of attendance or circumstance.

Initial _____

Total Number of Weeks Semester 1 August 7th December 22nd — 20 weeks. Initial _____

Total number of weeks Semester 2 January 8th -May 31st — 21 weeks initial _____

Total Amount Due (include registration)\$ _____ . Initial _____

Deposit Amount \$ _____ Total Remainder Owed \$ _____ . Initial _____

Payments may be made weekly in the amount of \$ _____ . Initial _____

No credits will be given for absences. Students are guaranteed space only for those weeks reserved in Payment Policy

I understand tuition is paid ahead. Payments are due on Fridays, for the upcoming week. Payments not made by Monday at 6:30pm will be considered late, and subject to a \$20 late fee. This fee will be added to my account and charged to my credit card on file. initial _____

Late Pick Up Fees

I understand Kid~Space Summer Camp is open from 6:30 am until 6:30pm.

A \$1 a minute late fee will apply after 6:35pm. This fee will be added to my account and charged to my credit card on file. Initial _____

I have read and understand the Kid~Space contract. I agree that my credit card may be charged in the event I do not make payments as specified in this contract. I understand that my card may be charged weekly for any outstanding fees owed on my account, including tuition, late fees, returned check fees, or unpaid lunch fees.

Signature

Date

A Master Card or Visa card must be held on file to complete registration.

Please Auto Charge my Account Weekly _____ Card Type Master Card _____ Visa _____

Credit Card Number: _____ Exp Date _____

Billing Street Address _____

Billing Zip Code _____ Name on Card _____ 3 Digit Code _____

Card Holder Signature

Date