

Cobb Middle School
After School Achievement Program (ASAP)
2019-2020
Enrollment Form
Please print

Child's Name: _____ Grade Level: _____
Guardian's Name: _____ Guardian's Name: _____
Phone #: _____ Phone #: _____
Email: _____ Email: _____

If applying for 'LCSB Discount', what is your worksite? _____

If applying for 'Sibling Discount', list the name(s) & grade level of sibling(s).

Select the day(s) your child will attend:

Monday Tuesday Wednesday Thursday Friday Drop-in

Emergency contact/Authorized to pick-up your child:

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

List any important information that the staff should know about (ex: medical conditions):

Do you give permission for your child to:

- be photographed or appear in video recordings during CMS ASAP? Yes or No
- access the internet for homework and extra practice? Yes or No

_____ (initial) I have read & will adhere to the fee schedule (including late pick-up & cycle fees).

_____ (initial) I have read & understand the polices of CMS ASAP.

Guardian Signature: _____ Date: _____
Guardian Signature: _____ Date: _____

*Any person responsible for fees must sign. One signature indicates sole responsibility.
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I have read & understand the polices of CMS ASAP.

Student Signature: _____ Date: _____