



230 NE 9<sup>th</sup> St., Bend, OR 97701 • (541) 419-3324 • info@samaralearningcenter.org • www.samaralearningcenter.org

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## SUMMER SUCCESS SKILLS GROUP ENROLLMENT FORM

Child's name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Home address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_  
Name of person(s) with whom child lives (if not parents): \_\_\_\_\_  
Relationship to applicant: \_\_\_\_\_  
Application completed by: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Please describe in your own words your child's strengths/challenges: \_\_\_\_\_

### Parent (or Guardian) Information

Primary Parent/Guardian Name: \_\_\_\_\_ Home phone: \_\_\_\_\_  
Address (if different from above): \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ e-mail \_\_\_\_\_  
Employer: \_\_\_\_\_ Work phone: \_\_\_\_\_  
Secondary Parent/Guardian's name: \_\_\_\_\_ Home phone: \_\_\_\_\_  
Address (if different from above): \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ e-mail \_\_\_\_\_  
Employer: \_\_\_\_\_ Work phone: \_\_\_\_\_

### Success Skills Group will be located at:

230 NE 9<sup>th</sup> St.

Bend, OR 97701

Take the driveway with the sign that reads "lower parking lot."

Class dates: Tuesday, Wednesday, Thursday, 7/17-19/2018, 7/24-26/2018, 7/31-8/2

Class Times: 1:30-3:30pm

Payment types accepted:

Check or Cash: \$195 covers all three weeks

Credit/Debit (2.9% + \$.30 processing fee): \$201 covers all three week

## Consent Statement -Medical Release Permission Form

I, the undersigned parent or guardian, do hereby grant permission for my child, \_\_\_\_\_ to participate in a program at/through/sponsored by the **Samara Learning Center**. I hereby hold the Samara Learning Center, Heather Chatem, all staff members, and its representatives harmless in the exercise of the authority. My child may receive necessary medical treatment in the event of inquiry or illness. In the event of emergency, I permit a hospital, doctor, or qualified health care provider to treat my child. It is requested that you complete the information below so that if your child requires a visit to the hospital while under the supervision of the school, this will allow the hospital to treat the injury.

## Emergency Information

Child's Name: \_\_\_\_\_ Gender: M \_\_\_\_\_ F \_\_\_\_\_  
Grade: \_\_\_\_\_ Age: \_\_\_\_\_  
Parent/Guardian's Name \_\_\_\_\_  
Home Address \_\_\_\_\_  
Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_  
Best phone number to reach: \_\_\_\_\_  
  
Insurance Name: \_\_\_\_\_  
Policy and Group Numbers: \_\_\_\_\_  
ALLERGIES \_\_\_\_\_

## Additional Information:

Is there any other information you would like us to know regarding your youth?

## Web, Social Media, & Marketing Release Form

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**YES**, the Samara Learning Center, Samara's collaborators, and/or news/information based publications may post photographs and/or videos of my child and their work on electronic media and promotional/news/informational material, including but not limited to: web pages, social media, or newspaper/magazine articles.

☐

**NO**, the Samara Learning Center, Samara's collaborators, or news/information based publications NOT post photographs and/or videos of my child and their work on electronic media and promotional/news/informational material, including but not limited to: web pages, social media, newspaper, or magazines.

Parent/Guardian name:

Printed \_\_\_\_\_

Signature \_\_\_\_\_

Administration Only:

**Payment type:**

Check: \_\_\_\_\_

Cash: \_\_\_\_\_

Card (2.9% + \$.30 fee included):

\_\_\_\_\_