island school
3-1875 Kaumualii Highway, Lihue, HI 96766
Phone: (808)246-0233
website: www.ischool.org

STUDENT/PARENT INFORMATION

2017-2018 Summer Enrichment Program

Student Information

Name _____ **Grade** _____ (SY 2017-2018)

Nick Name _____

Date of Birth _____

Parent(s)/Guardian(s)

Parent Names _____

Mailing Address _____

_____

Residential Address _____

_____

Home Phone _____ **Cell Phone** _____

Pager _____ **Fax** _____

Email address _____

COURSE/PROGRAM NAME & INSTRUCTOR NAME	TUITION AMOUNT
AMOUNT ENCLOSED:	

NOTE: All payments for Summer Enrichment programs due by June 2, 2017

I/We, understand that in signing this Enrollment contract for the 2017-2018 Summer Enrichment Program stated, I/we are agreeing to accept the rules and regulations of Island School as stated in the current Handbook (available in office). I/we give permission for the student named above to take part in all activities authorized by Island School. This includes, but is not limited to, sports and any trips that may be made away from the school. I/we release the school from any liability for any damage or injury suffered by my child in connection with these activities not due to Island School's sole negligence. I/we also agree to reimburse Island School for any loss which it may incur, including reasonable attorneys fees and costs, as a result of any claim which is submitted by or on behalf of my child named above for any such damage or injury. My signature below affirms that I/we have read, understand, and accept the terms and conditoins of this contract.

NO REFUND: ☐ I/We understand that the obligation to pay all fees for the Enrichment program is unconditional and that no portion of tuition paid will be refunded or cancelled in the event of absence, withdrawal, or dismissal from the Enrichment program. (Please initial box.)

Signature of Parent/Guardian _____ **Print Name** _____ **Date** _____

Signature of Parent/Guardian _____ **Print Name** _____ **Date** _____

ISLAND SCHOOL, 3-1875 Kaumualii Hwy, Lihue, HI 96766
Phone: (808) 246-0233 Fax: (808) 245-6053

STUDENT HEALTH INFORMATION

Student Name: _____

AUTHORIZATION OF CONSENT FOR TREATMENT OF MINOR

I/We, the undersigned, parent(s) of the above name student, a minor, do hereby authorize Island School as agent for the undersigned to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment or hospital care which is deemed advisable by, and is to be rendered under the provisions of the Medicine Practice Act, whether such diagnosis or treatment is rendered at the office of so said physician or at the hospital.

It is understood that this authorization is given in advance of any specific diagnosis treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent to give specific consent to any and all such diagnosis, treatment , or hospital care which the aforementioned physician in the exercise of his or her best judgment may deem advisable.

_____ _____ _____
Parent or Legal Guardian's Signature ***Date*** ***Daytime Phone #***

MEDICATION INFORMATION

Does your child take any daily medication? If so, the reason, dosage(s), and name of the medication?

_____

_____

****Please refer to Island School Handbook for our policy with regard to medication administered at school.***

Please explain any other condition(s) which will help us in scheduling appropriate activities for your student:

_____

_____

EMERGENCY CONTACT (if parents are not available):

Name: _____ **Name:** _____
Phone # _____ **Phone #** _____

Name: _____ **Name:** _____
Phone # _____ **Phone #** _____

_____ _____
Student's Physician's Name (please print) **Phone Number**

Name of Health Insurance Plan: _____

CONFIDENTIAL