



Early Elementary CLASS

Classroom Language and Academic Student Services
Summer, August 18-22, 2014 3:00pm-5:00pm

The BWF will not have any regularly scheduled sessions the week of August 18-22. Instead, we encourage you to register your child for our CLASS Program. The Early Elementary CLASS will concentrate on learning independence in a classroom. The children will practice language, reading, math, and writing within workstations as well as group learning and activities. The cost of CLASS is \$225 for the full week (5 days). Registration is for all 5 days. No partial week registrations will be accepted.

Child's Name: _____ Age: _____

While your child is in CLASS, we encourage you to attend a **FREE** Mini-Workshop aimed for your child's age range specifically. These Mini-Workshops will be from 9:30-10:30am. Please plan to attend.

- Monday 8/18: Strategies to Promote Skill Development for Early Elementary Students at Home
- Tuesday 8/19: Parents Promoting Fundamental Skills for Early Elementary
- Wednesday 8/20: Visual Schedules and Strategies for Early Elementary Aged Children
- Thursday 8/21: Social Interaction and Play Dates for Early Elementary
- Friday 8/22: Promoting Independence at Home: Self-Help Skills for Early Elementary

Payment Information: Check Cash Credit Card

Name on Card: _____

Credit Card Number: _____ CVC Code: _____

Billing Zip Code: _____ Phone Number: _____

Email Address: _____

Amount to be charged: _____ Signature: _____

****PLEASE NOTE: BWF grants and 3rd party grants may NOT be used to pay for CLASS.**

Emergency Contact and Medical Information for a Child

*Additional information about your child may be requested if necessary.

_____		_____		M	F
Child's Name		Date of Birth		Sex	
_____		_____			
Parent's/Guardian's Name		Parent's/Guardian's Name			
()	()	()	()		
_____		_____			
Home Phone	Work Phone	Home Phone	Work Phone		
_____		_____			
Address		Address			
_____		_____			
City, ST ZIP Code		City, ST ZIP Code			

Alternative Emergency Contacts

_____		_____			
Primary Emergency Contact		Secondary Emergency Contact			
()	()	()	()		
_____		_____			
Home Phone	Work Phone	Home Phone	Work Phone		
_____		_____			
Address		Address			
_____		_____			
City, ST ZIP Code		City, ST ZIP Code			

Medical Information

Hospital/Clinic Preference

Physician's Name	_____	Phone Number	_____
Insurance Company	_____	Policy Number	_____

Allergies/Special Health Considerations

In the event of a medical emergency, I give my permission for the staff at the Brent Woodall Foundation to perform first aid and/or CPR on my child.

Parent's/Guardian's Signature

Date