

**The Reading Station at Sea Of Strengths Academy
Summer Registration Form 2024**

Name of Student: _____

Age: _____ Entering Grade (2024-2025): _____ School: _____

Parent(s) Name(s): _____

Address: _____ City: _____ Zip _____

Phone: _____ Email: _____

Deposit: A deposit of \$100 is required at the time of registration. The \$100 deposit will be applied towards your summer program invoice. This is a non-refundable deposit unless circumstances result in the summer program closing. **YOUR DEPOSIT MUST BE RECEIVED TO RESERVE YOUR SPACE.**

Week(s) Attending:

___ June 17th - 21st

___ June 24th - June 28th

___ July 1st- July 5th (*Closed Thursday, July 4th- discounted week*)

___ July 8th - July 12th

Program Time:

___ Core Academic - 8:30 am -12:30 pm / Monday-Friday / \$300 a week

___ Core Academic & Arts Enrichment - 8:30 - 3:00 pm / Monday-Friday / \$350 a week

___ Intensive (Core Academic + Arts & Enrichment + Tutoring sessions (30 min x 5 days) / \$550 a week
Includes initial phonics and phonemic awareness assessments plus pre/post assessments
(Space is limited, must commit to all 4 weeks of the summer program, \$550 (non-refundable) deposit required to reserve your space)

YOUR DEPOSIT MUST BE RECEIVED BY FRIDAY, JUNE 14th TO RESERVE YOUR SPACE.

Has student previously been retained? (Yes / No) If yes, what grade? _____

Does student receive ESE services in school? (Yes / No)

If yes, please explain. (*Please provide students IEP/504 plan with registration*)

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Are there any medical/allergy conditions? (Yes / No)

If yes please explain: _____

Are there any medications taken during summer program hours? No ____ Yes ____
(If yes, you will need to complete a Medication Authorization Form.)

Is there any other additional information you would like to provide about your child?

Deposit: A deposit of \$100 is required at the time of registration. The \$100 deposit will be applied towards your summer program invoice. This is a non-refundable deposit.

Balance of your payment is due by Friday June 14th, 2024

Registration Changes: Changes can be made to your registration up to the cut off date of Friday June 21st, 2024. The \$100 deposit is non-refundable unless circumstances result in the summer program closing.

Late Changes: Cancellations of part or all of the summer program made after June 21st, 2024 will result in a one-week penalty (up to \$350).

Discounts:

_____ Former Summer Client- \$50.00 off. Year attended _____.

_____ Multi-Student- 10% off (You cannot combine this discount with current client discount).

_____ Current Tutoring Or School Client- 10% off (You cannot combine this discount with multi-student discount).

_____ Current Sarasota or Manatee County School Board Employee - 10% off (You cannot combine this discount with a multi-student discount).

Refer A Friend! If they sign up for the summer program, you will earn \$25.00 off your summer program bill, OR we will mail you a check if your bill is already paid in full.

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Please return this form, along with payment to complete your registration.

Please make checks payable to **Sea of Strengths Academy**

Mail to:

Sea of Strengths Academy
7313 International PL
Suite 90
Lakewood Ranch, FL 34240

For Questions, Please Contact Us:

Phone: (941) 361-1173
Fax: (941) 361-1174
Email: twhitehead@sosaschool.com

_____ I plan to use scholarship funds (Step Up For Students, AAA) to pay for summer services and I understand that I must pay SOSA upfront and submit my invoice to SUFS for reimbursement.

Name of scholarship received _____
Student ID # _____ Award ID # _____

Payment: Credit Card/Debit Card _____ Check _____ Check # _____

Name On Card: _____ Expires: __ __ / __ __

Visa ___ MasterCard ___ Discover ___ Card # _____

CCV _____ (The 3 digit code is found on the back of your card)

Billing Address: _____

City: _____ State: _____ Zip: _____

I Authorize The Reading Station to charge my credit/debit card in the amount of \$ _____

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Signature

Date

Emergency Contact Form

Sea Of Strengths School Inc. (DBA: The Reading Station), has my consent to provide necessary treatment or transportation for my child. I then request that I be notified of the situation. The undersigned will be responsible for all emergency treatment costs.

In the case of an accident or illness where immediate treatment of my child is not indicated, but where he/she is unable to remain at school, I request that the school contact me or my designee to arrange transportation for my child. If the school is unable to contact me, I request that one of the other persons listed on this form be contacted and requested to care for my child. In the event no person designated on this card is available, emergency medical services may be contacted for further assessment and possible transport and treatment. **I understand that I must notify the school if there are any changes in this health emergency information. By signing below, I understand that I will be responsible for all costs associated with treatment of my child, if necessary.**

Date: _____ Signature of Parent or Guardian: _____

Student's Name: _____ Date of Birth: _____

Sex: _____

Mother/Guardian's Name: _____

Employer: _____

Work Hours: (from ___ to ___) Work Phone: _____

Primary Phone: _____ Cell Phone: _____

Email Address: _____

Father/Guardian's Name: _____

Employer: _____

Work Hours: (from ___ to ___) Work Phone: _____

Primary Phone: _____ Cell phone: _____

Email Address: _____

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Emergency Contact Form (Continued)

Provide the information below for 3 persons you give *permission to transport* your child (photo identification will be required). If we can not reach you in case of emergency, we will contact the persons listed below. The individuals listed below will also be allowed to pick up your child if you are not available. Please notify us if you wish to add/remove a person from this list.

Name:	Relationship:	Contact Phone:	Other Phone:
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Family Physician: _____ Phone: _____

Family Dentist: _____ Phone: _____

Allergies: (please specify) _____

Wears Glasses: _____ Wears Contacts: _____

Other Health Concerns/Special instructions/Required Medications, etc.:

Custody Alert: Please give all pertinent information and explain:
