**The Reading Station at Sea Of Strengths Academy**
**Summer Registration Form 2025**

Name of Student: _____

Age:____ Entering Grade (2025-2026):_____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 16th - 20th

___ June 23rd - June 27th

___ June 30th - July 4th *(Closed Friday, July 4th- discounted week*)

___ July 7th - July 11th

**Program Time:**

___Core Academic - 8:30 am -12:30 pm / Monday-Friday / **$300 a week**

___ Core Plus 8:30 - 3:00 pm / Monday-Friday / **$350 a week**

___ Intensive (Core Academic + Core Plus + Daily 1:1 Intervention (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 13th 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.

**Payment of balance is due by Friday June 20th, 2025**

**Registration Changes:** Changes can be made to your registration up to the cut off date of Friday June 20th, 2025. 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 20th, 2025 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 packet, 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 to pay for summer services. I understand that I must pay out of pocket for the deposit and summer balance until my students' scholarship enrollment has been confirmed and funds have been received.**

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 $_____**

_____ _____
Signature Date

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## 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:

_____

_____