Spring Gardens Moravian Church

After School Assistance Programme

APPLICATION FORM

Part A

Applicant's name ________________________________ Age ____________________

Address _______________________________________ Denomination______________

Applicant's Present School _________________________ Grade Level _______________

Parent/ Guardian Name __________________________

Parent/ Guardian Occupation ________________________

Telephone Numbers: _____________(Home) ____________(Work) _____________(Cell)

Parent/ Guardian Expectations

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Parent/ Guardian Signature _______________________ Date _______________________

Student's Signature ______________________

Supervisor's Signature ________________________ Date________________________

Fees: EC $40.00 Weekly

FOR OFFICIAL USE ONLY

Fees Paid____________________

Month_______________________

Part B

Please put a tick √ in the appropriate box provided.

Does your child suffer from any of the following:	Yes	No
Vision problem	☐	☐
Hearing Problem	☐	☐
Reading problem	☐	☐

Has your child been tested for dyslexia?

Does your child suffer from any of the following health problems?

Asthma ☐ Allergies ☐ Other ☐

If other, Please Specify ____

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Is your child on medication?

Explain ____

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How would you describe your child's performance in school?

Poor ☐ Below Average ☐ Average ☐ Excellent ☐