AL FALAH ACADEMY

A full-time Islamic School in Gwinnett County

AFTER SCHOOL CARE ENROLLMENT PACKET 2024-2025 SCHOOL YEAR

This packet includes forms that are necessary to complete the after school care enrollment process. Additional forms may be required, depending on your situation. This packet includes:

- □ After School Care Student Registration Form
- □ After School Care Fees Agreement
- □ After School Care Pick-up Authorization Form
- □ After School Care Emergency Healthcare Information

Mail: 1850 Shackleford Ct, Norcross GA 30093 Web: www.AlFalahAcademy.com Email: info@AlFalahAcademy.com

Al Falah Academy does not discriminate based on race, color, religion, age, sex, national origin, or disability status.
All Donations to Al Falah Academy are tax deductible – IRS tax id: 27-2154656

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2024-2025 SCHOOL YEAR

After School Care Student Information: (PLEASE PRINT CLEARLY)

Student 1 information:

Last Name		First Name		Middle Name	
Grade		DOB		Gender □ Male □ Female	

Student 2 information:

Last Name		First Name		Middle Name	
Grade		DOB		Gender □ Male □ Female	

Student 3 information:

Last Name		First Name		Middle Name	
Grade		DOB		Gender □ Male □ Female	

Student 4 information:

Last Name		First Name		Middle Name	
Grade		DOB		Gender □ Male □ Female	

Student 5 information:

Last Name		First Name		Middle Name	
Grade		DOB		Gender □ Male □ Female	

STUDENT(S) INFORMATION: (PLEASE PRINT CLEARLY)

Address		City	

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County		State		Zip	
Race (used only to meet federal funding reporting requirements)	□ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or Other Pacific Islander □ White				

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FATHER / LEGAL GUARDIAN INFORMATION			
Last Name		First Name	
Address		City, State Zip	
Email Address		Home Phone	
Cell Phone		Work Phone	
Employer		Profession	
MOTHER / LEGAL GUARDIAN INFORMATION			
Last Name		First Name	
Address		City, State Zip	
Email Address		Home Phone	
Cell Phone		Work Phone	
Employer		Profession	

PARENTS / LEGAL GUARDIANS
□ Student lives with both parents
□ Parents are divorced/separated/widowed and student lives with □ mother □ father
□ Student does not live with either parent (please explain): In case of divorce/separation, please indicate who has legal custody: □ Both Parents □ Mother □ Father □ Other (please specify): Please attach a notarized copy of the court document indicating anything other than joint custody.

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PHOTOGRAPH AND VIDEO RELEASE

Al Falah Academy staff may take pictures or videos of the students. Please be aware that pictures will only appear in future promotional materials, including our brochure, Facebook, and videos…

☐ Yes, I authorize Al Falah Academy to take photos and videos of my child

☐ No, please do not use any photos of my child listed above

EMERGENCY CONTACTS

Name		Best # to call		Relationship	
Name		Best # to call		Relationship	
Name		Best # to call		Relationship	

PARENT / LEGAL GUARDIAN CERTIFICATION

I certify that the information submitted is correct to the best of my knowledge. I understand that information in this application and any supporting documents submitted will be confidential and only shared with relevant school personnel, as needed.

Name: ___________________________________ Relationship to Student: __________________________

Signature: ____ Date: __________________________

School Use only:

After School Care application Received on:_______________ Received by:____________________

Student Accepted: ☐ Yes ☐ No (reason):

____

Comments: ____

AL FALAH ACADEMY

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AFTER SCHOOL CARE FEES AGREEMENT
2024-2025 SCHOOL YEAR

PAYMENT PLAN

- It is very important to fill out **ALL** requested information.
- Payments are due **on the first of the month in advance of attendance**.
- After-school fees **do not roll over to next month.**
- **All payments will be collected via TADS on the same day as tuition payments are due, monthly.**

NOTE: Missed payments will result in withdrawal of the student from the After School Care Program.

AFTER-SCHOOL CARE PROGRAM: DATES AND TIMES

TOTAL NUMBER OF STUDENTS REGISTERED: □ 1 □ 2 □ 3 □ 4 □ 5
Please choose your child(ren)'s spot on days you know you will use this service. The number of units per day is in parentheses. The program is from 3:30pm to 6:00pm and Fridays from 12:30pm to 6:00pm

Mon (1 Unit)	□	Tue (1 Unit)	□	Wed (1 Unit)	□	Thu (1 Unit)	□	Fri (3 Units)	□

FEES PER STUDENT

The fee is based on the number of units per week/month PER CHILD. **Monday through Thursday are counted as one unit** each and **Friday is counted as three units** making the **full week (Monday through Friday) seven units**.
The cost of units is discounted as more units are reserved. **The monthly tuition**, based on the number of units, is shown in the table below.

One Unit/Month	Two Units/Month	Three Units/Month	Four Units/Month	Five Units/Month	Six Units/Month	Full Month
$40	**$75**	**$110**	**$125**	**$140**	**$165**	**$180**

□ Yes, Please enroll my child(ren) in the After-School Care Program and deduct the monthly fee from my account.
# of Students X # of Units per Month per Student = $ Total

___________ X _________________ = $_________

PARENT / LEGAL GUARDIAN AGREEMENT

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I agree, in the event of an unusual emergency, to call the school directly to notify the After-School Care Officer. I agree to pick-up my child(ren) **no later than 6pm**.
A late pick-up fee of $10 per 15 minutes or any fraction thereof will incur.
I agree the parent/guardian is responsible for the payment of the after-school care fees on time. I agree to abide by the above agreement and understand the school reserves the right to take action including removal from the program if the fees are not paid on time and/or the child is not picked up on time.

Name: ________________________________ Relationship to Student: ________________________

Signature: ____ Date: __________________________

AFTER SCHOOL CARE PICK-UP AUTHORIZATION FORM
2024-2025 SCHOOL YEAR

In addition to the parents or legal guardians, please list up to three other adults who are authorized to pick up your child. Each family will be given two free carpool numbers. If more are needed, they may be purchased at the front office for $5 each. Any adult, including the parents or legal guardians, who comes to pick up the child, must display the carpool number. If the carpool number tag is not available, please come to the front office for authorization verification.

CARPOOL TAG #: ____________

AUTHORIZED PICK-UP ALTERNATE			
Last Name		First Name	
Address		City, State Zip	
Phone		Relationship	

AUTHORIZED PICK-UP ALTERNATE			
Last Name		First Name	
Address		City, State Zip	
Phone		Relationship	

AUTHORIZED PICK-UP ALTERNATE			
Last Name		First Name	

Address		City, State Zip	
Phone		Relationship	

PARENT / LEGAL GUARDIAN AUTHORIZATION

I authorize the individuals named above to pick-up the student(s) named above from school. I understand that a driver's license or government issued ID will be required to verify the identity of the authorized pick-up alternate.

Name: __________________________________ Relationship to Student: _________________________

Signature: ____ Date: _________________________

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AFTER SCHOOL CARE EMERGENCY HEALTHCARE INFORMATION
2024-2025 SCHOOL YEAR

ENSURE EACH STUDENT HAS THIS FORM FILLED OUT

STUDENT 1 INFORMATION					
Last Name		First Name		Middle Name	
Date of Birth			Grade		

MEDICAL ISSUES AND ALLERGIES

Please list any allergies or other medical issues, with restrictions that need to be made. If none, write NONE.

____

____

MEDICATIONS

Will the clinician need to administer any medication during the day?
□ No □ Yes (If Yes, sign this section)

Please note: Both prescription and non-prescription medications are treated similarly, in that the parent must provide the medication in the original packaging, labeled clearly with your child's name and directions for use. No common medications, such as headache remedies, cough drops, or antibiotic cream, will be administered to any child unless it is prepared in accordance with these guidelines.

I, the undersigned parent/legal guardian, give permission for my son/daughter's medication to be administered by the Al Falah clinician. I have provided the medication, clearly labeled and with clear instructions, to the School Clinician.

Name: ________________________________ Relationship to Student: ________________________

Signature: ____ Date: ________________________

HOSPITAL TREATMENT RELEASE

In the event I cannot be reached, I give permission for my child named above to be transported to a hospital and authorize the hospital to provide emergency medical or surgical treatment. I assume full responsibility for all charges related to the above, and release the hospital, Al Falah Academy, and their agents, employees, administrators, and assigns from any and all liability, claims, and causes of action arising in connection with the transportation and/or treatment of the student named herein.

Name: ________________________________ Relationship to Student: ________________________

Signature: ____ Date: ________________________

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AFTER SCHOOL CARE EMERGENCY HEALTHCARE INFORMATION
2024-2025 SCHOOL YEAR

ENSURE EACH STUDENT HAS THIS FORM FILLED OUT

STUDENT 2 INFORMATION					
Last Name		First Name		Middle Name	
Date of Birth			Grade		

MEDICAL ISSUES AND ALLERGIES

Please list any allergies or other medical issues, with restrictions that need to be made. If none, write NONE.

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MEDICATIONS

Will the clinician need to administer any medication during the day?
□ No □ Yes (If Yes, sign this section)

Please note: Both prescription and non-prescription medications are treated similarly, in that the parent must provide the medication in the original packaging, labeled clearly with your child's name and directions for use. No common medications, such as headache remedies, cough drops, or antibiotic cream, will be administered to any child unless it is prepared in accordance with these guidelines.

I, the undersigned parent/legal guardian, give permission for my son/daughter's medication to be administered by the Al Falah clinician. I have provided the medication, clearly labeled and with clear instructions, to the School Clinician.

Name: ______________________________ Relationship to Student: _______________________

Signature: ____ Date: _______________________

HOSPITAL TREATMENT RELEASE

In the event I cannot be reached, I give permission for my child named above to be transported to a hospital and authorize the hospital to provide emergency medical or surgical treatment. I assume full responsibility for all charges related to the above, and release the hospital, Al Falah Academy, and their agents, employees, administrators, and assigns from any and all liability, claims, and causes of action arising in connection with the transportation and/or treatment of the student named herein.

Name: ________________________________ Relationship to Student: ________________________

Signature: ____ Date: ________________________

AL FALAH ACADEMY

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AFTER SCHOOL CARE EMERGENCY HEALTHCARE INFORMATION
2024-2025 SCHOOL YEAR

ENSURE EACH STUDENT HAS THIS FORM FILLED OUT

STUDENT 3 INFORMATION					
Last Name		First Name		Middle Name	
Date of Birth			Grade		

MEDICAL ISSUES AND ALLERGIES

Please list any allergies or other medical issues, with restrictions that need to be made. If none, write NONE.

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____

MEDICATIONS

Will the clinician need to administer any medication during the day?
□ No □ Yes (If Yes, sign this section)

Please note: Both prescription and non-prescription medications are treated similarly, in that the parent must provide the medication in the original packaging, labeled clearly with your child's name and directions for use. No common medications, such as headache remedies, cough drops, or antibiotic cream, will be administered to any child unless it is prepared in accordance with these guidelines.

I, the undersigned parent/legal guardian, give permission for my son/daughter's medication to be administered by the Al Falah clinician. I have provided the medication, clearly labeled and with clear instructions, to the School Clinician.

Name: __________________________________ Relationship to Student: __________________________

Signature: ____ Date: __________________________

HOSPITAL TREATMENT RELEASE

In the event I cannot be reached, I give permission for my child named above to be transported to a hospital and authorize the hospital to provide emergency medical or surgical treatment. I assume full responsibility for all charges related to the above, and release the hospital, Al Falah Academy, and their agents, employees, administrators, and assigns from any and all liability, claims, and causes of action arising in connection with the transportation and/or treatment of the student named herein.

Name: ________________________________ Relationship to Student: ________________________

Signature: ____ Date: ________________________

AL FALAH ACADEMY

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AFTER SCHOOL CARE EMERGENCY HEALTHCARE INFORMATION
2024-2025 SCHOOL YEAR

ENSURE EACH STUDENT HAS THIS FORM FILLED OUT

STUDENT 4 INFORMATION					
Last Name		First Name		Middle Name	
Date of Birth			Grade		

MEDICAL ISSUES AND ALLERGIES

Please list any allergies or other medical issues, with restrictions that need to be made. If none, write NONE.

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MEDICATIONS

Will the clinician need to administer any medication during the day?
□ No □ Yes (If Yes, sign this section)

Please note: Both prescription and non-prescription medications are treated similarly, in that the parent must provide the medication in the original packaging, labeled clearly with your child's name and directions for use. No common medications, such as headache remedies, cough drops, or antibiotic cream, will be administered to any child unless it is prepared in accordance with these guidelines.

I, the undersigned parent/legal guardian, give permission for my son/daughter's medication to be administered by the Al Falah clinician. I have provided the medication, clearly labeled and with clear instructions, to the School Clinician.

Name: ___________________________ Relationship to Student: ______________________

Signature: ___________________________________ Date: ______________________

HOSPITAL TREATMENT RELEASE

In the event I cannot be reached, I give permission for my child named above to be transported to a hospital and authorize the hospital to provide emergency medical or surgical treatment. I assume full responsibility for all charges related to the above, and release the hospital, Al Falah Academy, and their agents, employees, administrators, and assigns from any and all liability, claims, and causes of action arising in connection with the transportation and/or treatment of the student named herein.

Name: ________________________________ Relationship to Student: ________________________

Signature: ____ Date: ________________________

AL FALAH ACADEMY

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AFTER SCHOOL CARE EMERGENCY HEALTHCARE INFORMATION
2024-2025 SCHOOL YEAR

ENSURE EACH STUDENT HAS THIS FORM FILLED OUT

STUDENT 5 INFORMATION					
Last Name		First Name		Middle Name	
Date of Birth		Grade			

MEDICAL ISSUES AND ALLERGIES

Please list any allergies or other medical issues, with restrictions that need to be made. If none, write NONE.

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MEDICATIONS

Will the clinician need to administer any medication during the day?
□ No □ Yes (If Yes, sign this section)

Please note: Both prescription and non-prescription medications are treated similarly, in that the parent must provide the medication in the original packaging, labeled clearly with your child's name and directions for use. No common medications, such as headache remedies, cough drops, or antibiotic cream, will be administered to any child unless it is prepared in accordance with these guidelines.

I, the undersigned parent/legal guardian, give permission for my son/daughter's medication to be administered by the Al Falah clinician. I have provided the medication, clearly labeled and with clear instructions, to the School Clinician.

Name: ________________________________ Relationship to Student: ________________________

Signature: ____ Date: ________________________

HOSPITAL TREATMENT RELEASE

In the event I cannot be reached, I give permission for my child named above to be transported to a hospital and authorize the hospital to provide emergency medical or surgical treatment. I assume full responsibility for all charges related to the above, and release the hospital, Al Falah Academy, and their agents, employees, administrators, and assigns from any and all liability, claims, and causes of action arising in connection with the transportation and/or treatment of the student named herein.

Name: ________________________________ Relationship to Student: ________________________

Signature: ____ Date: ________________________