

E n r o l l m e n t & F i n a n c i a l A g r e e m e n t

By enrolling my child, I am agreeing to the following:

1. Show support to the faculty and staff of the school.
2. Give my child permission to attend all field trips and extra-curricular activities.
3. Allow my child's picture to be published by the school in any form of media.
4. Bring my child the required snack and/or lunch.
5. Pick up my child at the end of each day, on time.
6. Pay the program fee on or before the date my child will attend.
7. Pay any extra charges incurred within 48 hours of the charge.

Total registration amount: _____

Program fee of _____ for two weeks. (June 15-June 26, 2026)

Program fee of _____ for two weeks. (July 20-July 31, 2026)

Total Summer Enrichment cost: \$ _____

Payments are due before or on the first day of program use. Any extra charges incurred for late pick-up will be due within 48 hours of the occurrence.

This enrollment agreement is a financial contract. Any request to alter the payment schedule or tuition due must be made in writing to the Lakewood Lutheran Board of Education. This request may be approved or denied.

Signature: _____ Date: _____ SSN: _____

Billing name and address: _____

M e d i c a l I n f o r m a t i o n

I hereby authorize Lakewood Lutheran School, as our agent, to execute appropriate consent documents and/or give consent to surgical or medical treatment by any licensed physician or hospital in the State of Washington for our children on this application form when such treatment is deemed necessary.

Such consent shall include but is not limited to, administration of necessary anesthetics, medical treatment, tests, x-ray examinations, transfusions, injections of drugs, and the performing of whatever operations may be deemed necessary or advisable. Further, consent is granted to said physician to exercise his or her discretion in authorizing the disposal of any severed tissue or members.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, to provide the agent and my child's attending physician the authority to exercise, in their best judgment, what they deem necessary.

Student's name: _____

Family physician: _____ Phone: _____

Last tetanus: _____ Allergies: _____

Medical diseases: _____ Previous surgeries: _____

Special education needs: _____

Emotional or psychological needs (past or present): _____

Drug allergies: _____ Medications: _____

Insurance Co: _____ Policy holder: _____ Policy number: _____

I understand that I am financially responsible for the medical care for the above-named child. I further agree to pay all collection fees, collection costs, court costs, and attorney fees if legal action shall be instituted to collect all or any portion of the hospital's charges for medical care and services provided to the patient.

Father's signature: _____ Date: _____

Mother's signature: _____ Date: _____

Legal guardian's signature: _____ Date: _____

Witness' signature: _____ Date: _____

How did you hear about us? _____