TCBC Heritage School（三谷華夏課後書苑）

2014-2015 School Year Registration Form

1055 Serpentine Lane, Pleasanton, CA94566
Tel :(925) 462-7677 Fax :(925) 462-7659 E-mail:tcbcheritageschool@gmail.com Web: http://www.tvcbc.org

Students Info.	**Name of Students**		**Date of Birth**	**Gender (M/F)**	**Grade in Sept**	**Name of School**	**Food and/or Medicine Allergies**
	First Name	Last Name					
1st Child							
2nd Child							
3rd Child							

Name of parents or Guardians	**Relationship to Child**	**Work Phone**	**Cell Phone**	**Home Phone**	**Email Address**

Home Address_____ City_____ Zip Code_____

Fees for 2014-2015 School Year Beginning 8/25/2014		
Non-Refundable Register fee	Existing students (re-reg.): $0	New students: $30/child; $40/Family
(Full Time Students) Monthly Tuition Fee	Kindergartner (12-6pm)	$480/child 20% off for second Child
	1st Grade and up (3-6pm)	$380/Child 40% off for Second Child
(Part Time Students) Daily Tuition Fee	Kindergartner (12-6pm)	$30/day; Monthly:$430/4-day wk, $335/3-day wk
	1st Grade and up (3-6pm)	$23/day; Monthly:$338/4-day wk, $265/3-day wk

Elective Classes	**Art**	**Chinese**	**English**	**Bible Study**	**Math Olympiad**	**Dance**
Date	M	T &Th	T &Th	W	W & F	F
Time	4:15-5:45	4:15-5:00	5:10-6:00	4:15-5:00	4:00-5:00	4:30-5:30
Tuition Fee	$60/month	$60/month	$60/month	Free	$120/month	$50/month

Other fee	Material/yearly : $50/child	Pick-up from school : $5/per trip

Payment Policy: Tuition due on the 1st day of month. After 5th of the month $20 late fee will be charged.

No credit on school holidays or any personal absence from classes.

Classes are ended at 6:00PM Children are expected to be picked up no later than 6:30PM

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Medical Release: I, the undersigned, _____(initial) hereby give my permission to the physician or dentist selected by TCBC-Heritage School to hospitalize, to secure proper treatment and/or order an injection, anesthesia or surgery for my child as deemed necessary, after every attempt to contact the parent(s) and/or other emergency contact has failed. I further agree that I am fully responsible to pay all charges and expenses relating to such care and treatment. My signature below serves to indicate my willingness for my Health Insurance Company to be billed for any and all medical fees and services should they be needed. I agree that I will pay all charges and expenses not covered by my insurance. My signature below also serves as a medical release for the above mentioned child/children.

Health Insurance #:_____ Policy/Group # _____

Doctor's Name: _____ Doctor's Phone # _____

Parent / Guardian Signature. _____ Date: _____