



SCHOOL NAME:  SCHOOL PHONE:  SCHOOL ADDRESS:   SCHOOL DISMISSAL TIME:	Start Date: _____  End Date: _____	Please Circle!  After School Care Days:  M T W TH F
--	--	---

Child's Name:	DOB: _____ _/_/____	Age:	Grade in Fall 2021:
Address:	City/State/Zip:	Phone:	

How did you hear about So's Afterschool Program?  
 \_\_\_\_\_

**Primary Parent/Guardian Contact Information**    Mother    Father    Other: \_\_\_\_\_

Primary Parent/Guardian Name:	DOB: _/_/____ Gender: __M or __F	Cell #: Home #: Work #:
Home Address (if different from child):	City/State/Zip:	
Email:	May So's release to non custodial Parent?: __Y __N __N/A	Driver's License #:

**Secondary Parent/Guardian Contact Information**    Mother    Father    Other: \_\_\_\_\_

Secondary Parent/Guardian Name:	DOB: _/_/____ Gender: __M or __F	Cell #: Home #: Work #:
Home Address (if different from child):	City/State/Zip:	
Email:		Driver's License #:

**Emergency Contact/Authorized Pick Up (other than parents):**

Name:	Home Address:	City/State/Zip:
-------	---------------	-----------------

Relationship to Child:	Phone #:	Driver's License #:
------------------------	----------	---------------------

**Additional Authorized Pick Up (other than parents):**

Name:	Phone #:	Driver's License #:
-------	----------	---------------------

**Health History**

**Severe/Life-Threatening Allergies** - Please list any food, environmental, or other allergies which are severe, life-threatening, or require emergency medication:

---



---

**Special Considerations/Needs** - Please list any Special Considerations relevant to your child, such as existing illnesses, previous serious illnesses, injuries or hospitalizations within the past 12 months, activity restrictions, developmental age, chronic health concerns, any medication prescribed for long-term continuous use, and any other information which caregivers should be aware of:

---



---

**Required Medications** - Please list any prescription medications which require administration during program hours or during emergency situations:

---

- \*Prescription medications require written note and instructions by a physician
- \*Medication must be current
- \*Medication must be in original container

**Authorization for Medical Treatment**

In the event that I cannot be reached to make arrangements for medical treatment, I authorize So's Taekwondo staff to administer first aid/or transport to the nearest hospital or emergency care facility.

Name of Licensed Physician or Emergency-Care Facility:

---

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

I certify that \_\_\_\_\_ has been examined by a licensed physician in the past 12 months, and is able to participate in So's Taekwondo's after school program. The Health History is correct to my knowledge, and the person herein described has permission to engage in all prescribed activities, expect as noted by examining physician and me.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Admission Agreement**

Initial	I give permission for my child to be transported in an authorized So's vehicle for planned trips.
Initial	I give permission for my child to view a Director approved PG movie, though it is not part of regularly scheduled lesson plans.
Initial	I certify that my child's current immunization records and TB test can be located at the school my child is currently attending.
Initial	I understand that I will be charged an additional \$1.00 every minute I am late after the end of the program.
Initial	So's staff is not trained to review legal documents or court decrees. Decisions regarding who is authorized to pick up a child will be governed by the Primary Parent/Guardian information listed on this document. No person under 18 years old may pick up a child without a signed affidavit on file.
Initial	So's Taekwondo is hereby granted permission to use any individual or group photograph and/or video showing my child in So's Taekwondo activities for the use of public relations, promotional, and advertising purposes.

Initial	I understand the behavior policy (expulsion from our program is possible if deemed necessary), and the zero tolerance for bullying policy.
Initial	I understand that it is my responsibility to notify So's Taekwondo by 1PM daily if my child will not attend the program that day. I understand that I must call the designated site phone (717-521-9238).
Initial	I understand that So's Taekwondo will be closed on select holidays and care may be available at an additional cost. I further understand that during inclement weather, So's Taekwondo will not refund or pro-rate the weekly fee.

I have read the Admission Agreement and fully agree to its terms. By my signature, and of my free will, I do hereby agree to indemnify and save harmless So's Taekwondo, LLC from any and all claims or demand, cost or expense arising out of any injuries, damages or other losses, whether personal or property, sustained by me or any party to who I am responsible.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

I have read and understand So's Taekwondo's Payment Agreement; I accept my payment plan and agree to abide by all of the policies in place. I understand that failure to uphold my payment arrangement will result in my child being suspended from the program until the account is in good standing.

Primary Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

So's Taekwondo will not have after school program for your child on Holiday breaks OR if your child's school is closed, however, So's Taekwondo will run the program on weather related early dismissals.

### COVID-19 LIABILITY WAIVER

Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19 The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people. So's Taekwondo has put in place preventative measures to reduce the spread of COVID-19; however, So's Taekwondo cannot guarantee that you or your child(ren) will not become infected with COVID-19. Further, attending So's could increase your risk and your child(ren)'s risk of contracting COVID-19. By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that my child(ren) and I may be exposed to or infected by COVID-19 by attending So's and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at So's may result from the actions, omissions, or negligence of myself and others, including, but not limited to, So's employees, volunteers, and program participants and their families. I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to my child(ren) or myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my child(ren) may experience or incur in connection with my child(ren)'s attendance at So's or participation in So's programming ("Claims"). On my behalf, and on behalf of my children, I hereby release, covenant not to sue, discharge, and hold harmless the So's, its employees, agents, and representatives, of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of the So's, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any So's program.

Primary Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please Complete Sections 3, 4, and 8! We will complete the rest, and review it with you for your signature.

**1. BUSINESS INFORMATION**

Business Name: \_\_\_\_\_ Business: \_\_\_\_\_ Client ID: \_\_\_\_\_

Business Address: \_\_\_\_\_

2.  NEW (Never before submitted to MSI)  REPLACEMENT (This option cancels existing agreement with MSI)  FINAL PAYMENT DUE ON EXISTING AGREEMENT: dd yy

RENEWAL (Does not affect existing agreement with MSI)  UPGRADE (This option upgrades existing agreement with MSI)  MEMBER SOLUTIONS ACCOUNT ID: \_\_\_\_\_

**3. CUSTOMER INFORMATION** (Complete each item)

Customer (First & Last Name): \_\_\_\_\_

DOB: dd yy yy Home Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Work Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_ Cell Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State or Prov: \_\_\_\_\_ Zip or PC: \_\_\_\_\_

Member 1 (First, Last Name): \_\_\_\_\_ DOB: dd yy yy

Member 2 (First, Last Name): \_\_\_\_\_ DOB: dd yy yy

**4. EMAIL ADDRESS**

I authorize MSI to notify me at the following email address when my statement or other correspondence is available and ready to view online.

\_\_\_\_\_

**5. PROGRAM DESCRIPTION**

\_\_\_\_\_

**6a. TERM** (Complete only 6a. OR 6c.)

1. Program Price	\$	_____	6. Balance/Total Billed (line 3 +/- lines 4 & 5)	\$	_____
2. Downpay- (Tendered)	- \$	_____	7. Number of		_____
3. Sub-Total (line 1 minus line 2)	\$	_____	8. Amount Due (line 6 divided by line	\$	_____
4. Service Charge	+ \$	_____	9. Program Start Date		dd yy
5. Other +/-	+/- \$	_____	10. Program Expiration Date		dd yy

**6b. AUTOMATIC RENEWAL OPTIONS**

If auto-renewal selected, upon Program Expiration Date (6a.10), this Agreement will continually renew as set forth below with the same billing method, frequency and due date. Length of the renewal period is determined by type (Open or Term). MSI must receive written notice not less than 30 days prior to Program Expiration to terminate a scheduled auto-renewal. If the Agreement renews, termination is governed by the renewal type.

Open Renewal Payment Amount \$ \_\_\_\_\_ Cancellation Notice Days \_\_\_\_\_

Term Renewal No. Payments \_\_\_\_\_ Renewal % \_\_\_\_\_ \$ \_\_\_\_\_ Payment Amount \$ \_\_\_\_\_ Program \_\_\_\_\_

(Unless otherwise stated, a 30-day written cancellation notice is required.) (Each renewal term is for the same Program Length. To cancel, MSI must receive written notice not less than 30 days prior to the expiration date of any Renewal Term. If renewed, you are responsible for payment for the entire Renewal Term.)

**6c. OPEN** (for Ongoing Memberships only)

1. Ongoing Payment Amount \$ \_\_\_\_\_ Cancellation Days \_\_\_\_\_ (Unless otherwise stated, a 30-day written cancellation notice is required.)

**7. FIRST PAYMENT DUE DATE/ BILLING FREQUENCY** (applicable to both Term and Open)

First Payment Due On: dd yy

Billing Frequency (due monthly if not selected):  Monthly  Every \_\_\_\_\_ (mos)  Weekly  Every \_\_\_\_\_ (wks)

Please note that coupon and statement are not valid options for weekly or bi-weekly billing frequencies.

A late fee of \$ \_\_\_\_\_ will be assessed for any \_\_\_\_\_ days past due. If not specified a late fee of \$10 will be due for any payment 5 days past due.

**8. BILLING METHOD**  Bank Draft  Credit/Debit Card  Statement  Coupon (available for Term Memberships only)

Complete either Bank Draft or Credit/Debit Card if Selected as Billing Method Above

Bank Draft ATTACH VOIDED CHECK  Checking  Sav- \_\_\_\_\_

Name of Financial Institution: \_\_\_\_\_ Check No. \_\_\_\_\_

Routing No. (First 9 digits): \_\_\_\_\_ Account No. \_\_\_\_\_

Credit/Debit Card Account No. (Visa, MasterCard, American Express and Discover accepted) \_\_\_\_\_ Expiration: \_\_\_\_/\_\_\_\_/yy CW\* \_\_\_\_\_ \*For initial transaction only.

**9. SPECIAL INSTRUCTIONS** (or ADDITIONAL MEMBERS)

\_\_\_\_\_

**BILLING AGREEMENT**

This Agreement is between Member Solutions ("MSI") and Customer in relation to Business. The phrase "888-277-4408 Member Fees" will appear on your bank or credit card statement. Any account more than 5 days past due will be charged a \$10.00 late fee unless otherwise stated herein. Any returned payment will be assessed a \$25.00 fee. Any unsuccessful scheduled electronic transaction is subject to a \$15.00 processing fee. MSI is not responsible for any bank fees incurred by Customer. MSI has the sole right to modify any payment due date and to resubmit returned or declined items (plus applicable fees) without prior notice. If the Billing Method is modified during the term of this Agreement, the payment amount may be adjusted accordingly (if applicable, by Business).

**MEMBER'S (CUSTOMER'S) RIGHT TO CANCEL**

If you wish to cancel this Agreement, you may cancel by delivering or mailing by certified mail, return receipt requested, written notice to the Business. The notice must say you do not wish to be bound by the Agreement and must be delivered or mailed before 12 midnight of the third business day after you sign this Agreement. The notice must be delivered or mailed to MSI and the Business at the addresses set forth herein. If you cancel, any downpayment or initial fee may not be refundable and the Business may be entitled to a portion of the total Agreement price.

If the Business goes out of business or refuses to give you a refund, there may be a bond or letter of credit under which you are entitled to collect. MSI will not be responsible for any refunds. Enforcement of applicable consumer statutes is by your state or local authority. If you feel your rights have been violated you should contact your state or local Consumer Affairs Office.

I have read and understood this entire Agreement and I agree to comply with all the provisions, terms and conditions set forth on both sides of this Agreement including but not limited to paying the Balance/Total Billed (6a.6). I further agree that once signed, this Agreement is a legally binding and enforceable obligation. I acknowledge I have received a copy of this Agreement.

 **Member Solutions** BILLING INQUIRIES 888-277-4408 PO Box 297, Hatboro, PA 19040

Print Customer Name: \_\_\_\_\_

Customer Signature: \_\_\_\_\_

Authorized Business Representative: \_\_\_\_\_

Date (mm/dd/yy) \_\_\_\_\_ universalW060217