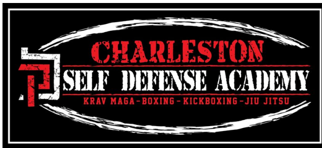

Charleston Self Defense: Virtual School Center

Registration Form

Send completed forms to charlestonfitmma@gmail.com

Parent or Guardian Information 1

First Name: ______________________ Last Name: ______________________

Phone Number: ______________________ Work Number: ______________________

Email: ______________________

Street Address: ______________________

City: ______________ State: ____________ Zip Code: ____________

Parent or Guardian Information 2

First Name: ______________________ Last Name: ______________________

Phone Number: ______________________ Work Number: ______________________

Email: ______________________

Street Address: ______________________

City: ______________ State: ____________ Zip Code: ____________

Student Information:

Student 1: First Name: ______________________ Last Name: ______________________

Age: ______________________ Grade: ______________________

School: ______________________ Teacher: ______________________

Does the student have any allergies or special needs? Please explain: ______________________

____

____

Student 2: First Name: ______________________ Last Name: ______________________

Age: ______________________ Grade: ______________________

School: ______________________ Teacher: ______________________

Does the student have any allergies or special needs? Please explain: ______________________

____

____

Student 3: First Name: ______________________ Last Name: ______________________

Age: ______________________ Grade: ______________________

School: ______________________ Teacher: ______________________

Does the student have any allergies or special needs? Please explain: ______________________

____

____

Student 4: First Name: ______________________________ Last Name: ____________________________
Age:___________________________________ Grade:_________________________________
School: _________________________________ Teacher: ______________________________
Does the student have any allergies or special needs? Please explain: _______________________________
____
____

Custody and Transportation

Are there any parents or individuals who are specifically NOT ALLOWED to have contact with the child?
Please explain:____
____
____

Emergency Contact 1

First Name: __________________________________ Last Name:_____________________________________

Phone Number:________________________________ Work Number:___________________________________

This person may check out and pick up my child in an emergency: Yes: ________ No:__________

Emergency Contact 2

First Name: __________________________________ Last Name:_____________________________________

Phone Number:________________________________ Work Number:___________________________________

This person may check out and pick up my child in an emergency: Yes: ________ No:__________

Payment Information:
I agree to pay $69 per week per child plus applicable taxes and fees for Virtual School Center services, and an additional $40 per week for after school care, pro-rated at a daily rate of $8 per day per child for any late pickup later than 15 minutes after the end of VSC program hours. The initial charge will be: ____________.

Number of children registered: __________________
Number of VSC days purchased: __________________
Number of after school days purchased: __________________
Total Cost: __________________

I agree that payments are non-refundable except in the case of children with an illness documented with a doctor's note. I agree to pay the above rate weekly, and will give notice of enrollment changes by **Wednesday at 5:00 PM** of each week for the following week.

Card Number: ____

Expiration Date: _____________________________ Security Code:_____________________________

Name as it appears on Credit Card:____

Street Address (if different than above)____

Signature:____ Date:______________________________