ACTION CENTERED TUTORING SERVICES
Making a difference… one child at a time
35 Chestnut Street, Springfield, MA 01103
413-731-9810 acts1986@gmail.com

Student Application

Personal Information (Please print):

Student's Name: _____ Sex: M F
(Last) (First) (Middle) (Circle one.)

Address: _____
(Street) (City) (ZIP)

Telephone: _____ Student's Date of Birth: _____ Age: _____

School: _____ Grade: _____ Teacher: _____

Name of Parent or Guardian: _____

Did your child participate in the ACTS tutoring program last year? [ ] Yes [ ] No

Emergency/Medical Information:

Person other than parent to contact in the event of an emergency: _____

Phone: _____ Relationship to the student: _____

Does your child have a hearing or speech problem? [ ] Yes [ ] No If yes, please describe: _____

_____

Does your child have any allergies (for example, insect bites, food allergies, etc). Yes [ ] No [ ] If Yes, please describe:

_____

If your child uses an inhaler please bring a form from your child's doctor.

Please identify insurance coverage: _____/_____
(Carrier) (Number)

Please indicate any individuals (other than yourself) to whom your child may be released:
_____

Please indicate any individuals to whom your child may NOT be released:
_____

Educational Information:

What kinds of academic help does your child need?
_____

_____

I understand that a personal interview will be offered and may be conducted with me prior to the placement of my child in the ACTS tutoring program. I give my permission for my child to receive academic tutoring and mentoring in the ACTS tutoring program.

Name: _____ Date:_____
(Signature of parent or Guardian)

Form continues on the other side.

Action Centered Tutoring Services
PARENT/GUARDIAN PERMISSIONS

Dear Parent or Guardian,

ACTS needs your permission for several kinds of information and activities to enable your child to get the full benefit of the program, and for safety reasons. ***Please initial each release to which you give permission.***

SCHOOL INFORMATION

I understand that in order to better address my child's academic needs, ACTS needs information from his/her school or teacher. I give permission for ACTS to acquire academic information from my child's school and teacher as needed.

_____ Date:_____
(Parent/Guardian initials)

CLUB TIME

I understand that ACTS conducts a Club Time, separate from academic tutoring time, which includes Bible lessons and instruction in Christian values. I give permission for my child to participate in the Club Time activities.

_____ Date:_____
(Parent/Guardian initials)

PHOTO PUBLISHING

I give permission for ACTS to photograph or videotape my child and to use such a photo or video picture in the ACTS web site, newsletter and other publications, and to release to the local news media.

_____ Date:_____
(Parent/Guardian initials)

TRANSPORTATION

I give permission for ACTS to transport my child in the event of medical needs, an unforeseen family circumstance, or other emergency. Otherwise, I understand I am responsible for getting my child to and from the program.

_____ Date:_____
(Parent/Guardian initials)

LOCATION

ACTS has tutoring programs at 10 locations around Springfield:

Mondays
St. John's Congregational Church, 45 Hancock St., 3:30-5:30 pm
Evangelical Covenant Church, 915 Plumtree Rd, 4:00-6:00 pm
JC Williams Community Center, 116 Florence St., 4:00-6:00 pm
Celestial Praise COG, 321 Wilbraham Rd, 4:15-6:00 pm

Tuesdays
Bethesda Lutheran Church, 455 Island Pond Rd., 4:00-6:00 pm
Orchard Covenant Church, 95 Berkshire St., 4:00-6:00 pm
Allen Park Community Room, 251 Allen Park Rd., 6:00-8:00 pm

Wednesdays
Christ Church Cathedral, 35 Chestnut St., 4:00 - 6:00 pm

Thursdays
Faith United Church, 52 Sumner Ave., 3:30 - 5:30 pm
YMCA North End Center, 1772 Dwight St., 3:30 - 5:30 pm

I am most interested in the ACTS program at _____ [ ] Check if not sure/no preference.

Please **PRINT** name of Parent or Guardian:

Name: _____ Date:_____