ACTION CENTERED TUTORING SERVICES
35 Chestnut Street, Springfield, MA 01103 • 413-731-9810 • acts1986@gmail.com

Student Application 2023-2024

Personal Information (please print):

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

Address: _____ Student's Date of Birth: _____ Age: ___
(Street) (ZIP)

School: _____ Grade: _____ Teacher: _____

Did your child participate in ACTS last year? Yes No (Circle one.) Do you have a car or reliable access to a car? Yes No (Circle one.)

Name of Parent or Guardian: _____ Email: _____

Cell phone: _____ Text? Yes No (Circle one.) Home or work phone: _____

Emergency/Medical Information:

Person other than parent to contact in an emergency: _____

Relationship to the student: _____

Cell phone: _____ Text? Yes No (Circle one.) Home or work phone: _____

Does your child have a hearing or speech problem? Yes No (Circle one.) If yes, please describe: _____

_____

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

_____

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

Insurance coverage: _____ / _____
(Carrier) (Number)

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

_____

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

_____

Educational Information:

What academic help does your child need? _____

I understand that a personal interview may be conducted with me prior to the placement of my child in the ACTS 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)

PLEASE TURN OVER ⇨

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 in the ACTS web site, newsletter and other publications, and to release to the local news media.

_____ Date:_____
(Parent/Guardian initials)

EMERGENCY 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)

TUTORING SITES LOCATIONS

ACTS has tutoring programs at several locations throughout Springfield:

Mondays

Brookings Elementary School, 433 Walnut St., 4:00-6:00 pm

St. John's Congregational Church, 45 Hancock St., 3:30 - 5:30 pm

Tuesdays

Orchard Covenant Church, 95 Berkshire St., 4:00-6:00 pm (2024)

Colonial Estates, One Beacon Circle, 4:00 - 6:00 pm

Wednesdays

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

Evangelical Covenant Church, 915 Plumtree Rd, 4:00 - 6:00 pm

Thursdays

Skyview Downtown, 10 Chestnut Street 4:00 - 6:00 pm

Christina's House, 367 Union Street, 4:00 - 6:00 pm (2024)

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

PRINT name of Parent or Guardian:

Name: _____ Date: _____